An Examination of How Overseas Qualified Nurses and Australian Nurses Work Together in the Australian Context

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Statement of originality

The thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968.

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Abbreviations

AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AIN	Assistant in nursing
ANMAC	Australian Nursing and Midwifery Accreditation Council
ANMC	Australian Nursing and Midwifery Council
ANMF	Australian Nursing and Midwifery Federation
ANs	Australian Nurses.
ACSQHS	Australian Commission of Safety and Quality in Health Service
CDNM	Council of Deans of Nursing and Midwifery, Australia and New Zealand
CE	Code of Ethics
CEC	Clinical Excellence Commission
CNE	Clinical Nurse Educator
CPC	Code of Professional Conduct for Nurses in Australia
DIAC	Department of Immigration and Citizenship
DIBP	Department of Immigration and Border Protection
DD cupboard	Dangerous drug cupboard.
EN	Enrolled Nurse
ESB	English Speaking Background
HETI	Health Education and Training Institute
HNELHD	Hunter New England Local Health District (HNE Health)
IELTS	International English Language Testing System
HSU	Health Service Union
ICN	International Council of Nurses
ICNM	International Centre on Nurse Migration
ICNCE	International Council of Nurses Code of Ethics
IIMS	Incident and Injury Management System
LHD	Local Health District
MHLO	Multicultural Health Liaison Officer
NAMO	Nursing and Midwifery Office, NSW
NESB	Non- English Speaking Background
NMBA	Nursing and Midwifery Board of Australia
NMBANS	Nursing and Midwifery Board of Australia's Nursing Standards for Nurses
NSQHS	National Safety and Quality Health Service
NSW NMA	New South Wales Nursing and Midwifery Association

PCP	Policy Compliance Procedure
RCON	Royal College of Nursing
RN	Registered nurse
OET	Occupational English Test
OQNs	Overseas Qualified Nurses
TTMRA	Trans-Tasman Mutual Recognition Arrangement

Glossary

Australian Nurse (AN): An AN is used to represent nurses who are born and were trained/educated in order to satisfy requirements for qualification in Australia.

Assistant In Nursing (AIN): An AIN works as a member of the nursing team, assisting nurses and supporting patients in their activities of daily living (NSW Ministry of Health, 2016). Most AIN positions require a Certificate III course, which generally runs over five months full-time or 11 months part-time study.

Enrolled Nurse (EN): An EN undertakes an 18 months or two year prescribed course to achieve a Diploma in Enrolled Nursing. They provide nursing care, working under the direction and supervision of a Registered Nurse. Enrolled Nurses perform basic care such as checking vital signs, and assisting with personal hygiene.

Endorsed Enrolled Nurse (EEN); an EEN is an Enrolled Nurse with an additional medication endorsement: The EEN may thus administer medications specified as within their scope of practice.

Local nurses RNs who are born and trained or qualified in their home countries**.**

Overseas Qualified Nurse (OQN): An OQN has obtained her/his first qualification as a RN in a country other than their present host country. The term OQN is used to represent terms in common usage such as the international nurses, internationally recruited nurses, overseas nurses, foreign nurses and migrant nurses.

Nurse: A term used to describe Registered Nurses

Registered Nurse (RN): An RN is a person with appropriate educational preparation after completing a three year pre nursing registration course and thus deemed competent for practice; The RN is either registered and licensed under the Australian Health Practitioner Regulation Agency and thus under the requirements within the appropriate Nursing Act is able to practice nursing in Australia. Roles and functions may include but are not limited to administration, team leader or unit manager duties, medication administration, assessment and management of the client including the need for complex nursing care, specialised nursing care or involvement in research.

Symbols

..//.. Material edited from original interview transcripts

… Pause contained in the original interview transcripts

[square brackets] Researcher's comments, added to provide clarity or explanation

Synopsis

Increasingly, cultural diversity is a feature of the Australian nursing workforce due to globalisation and global movement of the workforce. Whilst much of this diversity has resulted from general migration over generations, a significant proportion results from nurses who migrate after qualifying as a nurse in another country. The participation of these nurses in the nursing workforce has the potential to enrich workforce culture and practice. However, cultural diversity in the workplace has also been reported as challenging for both incoming and receiving nurses; this calls for more research into the context, culture and experiences in multicultural workplaces.

This study examined how overseas qualified nurses (OQNs) and Australian nurses (ANs) work together in the Australian context. Specifically, it explored the experiences of OQNs and ANs working together in a Local Health District (LHD). Unlike previous studies, this study aimed to examine and give voice to both OQNs and ANs using Critical Social Theory as the theoretical framework and Interpretive Description as the methodological framework. The study enabled articulation of the nurses' perspectives of factors contributing to their experiences, explored the practices and underlying mindsets that both groups of nurses employed while working together, and identified strategies or resources that helped to overcome some of the difficulties they experience in their working environment. The experiences of these nurses were compared with the expectations for and intentions of RNs in Australia formally outlined by professional, organisational policies and regulations.

Findings suggest that the experiences of the participants were personally, professionally, organisationally and socio-culturally constructed. All nurses were committed to providing safe and quality nursing care to their patients and to a collaborative working relationship with each other. However, the extent to which they perceived they were 'working together' in a novel situation was questionable in that

they were not equipped to work with ‘differences’ and ‘the unknown’. They reported having difficulty in building optimal working relationships due to experiences where exclusion, bullying, distrust, disrespect, racism and lack of organisational and supportive leadership were evident in their practice environment. Therefore, there was professional and cognitive dissonance, and power differentials in their working relationships. The study identified that facilitative influences for them to work together well included how well the nurses themselves managed any dissonance, power differential and differences through attempts at collegial engagement and high levels of civility as well as through strategic organisational support.

The study assists to build on knowledge of the topic and to guide the development of strategies to enhance cross-cultural experiences of both OQNs and ANs and provide suggestions for reciprocal benefits. Further, in addressing this area of ongoing concern in health care settings, the findings also inform workforce policy and future research and educational strategies related to OQNs and ANs in the workplace and for the Australian nursing profession.

Key words: Overseas qualified nurses, Australian nurses, cultural diversity, experience, cross-cultural working, acculturation

Chapter 1 **INTRODUCTION**

1.1 **BACKGROUND**

The global movement of overseas qualified nurses (OQNs), together with the active recruitment of OQNs to Australia has increased the number of OQNs in the Australian nursing workforce over the past few decades (Buchan, 2009b; Ohr, Parker, Jeong, & Joyce, 2011). OQNs contribute to reducing the shortage of nurses in the Australian nursing workforce and to the development of a diverse workforce to meet the needs of the multicultural Australian population (Health Workforce Australia, 2012; Jeon & Chenoweth, 2007; Konno, 2006). However, it is also well documented that OQNs working in host countries have experienced many challenges and difficulties (Deegan & Simkin, 2010; Konno, 2006; Omeri & Atkins, 2002; Wheeler, Foster, & Hepburn, 2013; Xu, Gutierrez, & Kim, 2008; Zhou, Windsor, Theobald, & Coyer, 2011). These challenges and difficulties impact on OQN themselves, local nurses and nursing practice generally. Concerns have been raised about the individual nurses' well-being and job satisfaction, recruitment and retention of nurses, and the quality and safety of care provided (Alexis, Vydelingum, & Robbins, 2007; Gerrish & Griffith, 2004; Humphresis, 2009; Konno, 2006; Newton, Pillay, & Higginbottom, 2012; O'Brien & Ackroyd, 2012; Omeri & Atkins, 2002; Smith, Allan, Henry, Larsen, & Mackintosh, 2007; Xu & He, 2012). Consequently, different strategies directed largely towards integrating OQNs to the host country's expectations for nursing practice and within society have been implemented. However, challenges and difficulties persist.

The migration of nurses is a worldwide phenomenon. Besides the general migration of people around the world, many countries experiencing a shortage of nurses, including Australia, have actively recruited OQNs to meet their needs for particular areas within the nursing workforce. Thirty per cent of all nurses working in Australia were born

overseas with more than 15 percent of RNs having obtained their first nursing registration overseas (Australian Institute of Health and Welfare, 2009).

The presence of OQNs as part of a global nursing workforce has developed a culturally and linguistically diverse nursing workforce in receiving countries, but has also resulted in a number of challenges and issues, which potentially impact on the provision of quality nursing care. One of the challenges that have been frequently discussed centres on the experiences of OQNs in the workplace. These include reports of racism, and discrimination, communication difficulties and the need to identify differences in nursing practice. These challenges arise from working across cultures in relationships with local nurses in health care organisations (Omeri & Atkins, 2002; Zhou et al., 2011).

Another challenge for the health care organisations who receive these OQNs is a need to support them and to ensure their nursing practice is commensurate with expected standards and processes. With increasing numbers of OQNs in the Local Heath District (LHD) where this study is situated, the challenges and issues related to OQNs are widely discussed. These challenges are often reported in the form of 'incidents' or 'complaints' about OQNs. However, the experiences of nurses, both ANs and OQNs in relation to these incidents and complaints, remain largely unexplored and unheard in a formal way.

This conception of the study was timely in that it has coincided with the publication of the Garling Report, a Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (Garling, 2008). Garling identified a number of problems associated with support and supervision of overseas-trained doctors and nurses, discrepancies and lack of induction programs, and inconsistency of recognition of prior experiences and qualifications and transparency of recruitment processes. He recommended appropriate measures be taken to assist overseas doctors and nurses to ensure "smooth transition" into the workplace.

The current study is especially pertinent to the Local Health District (LHD) the where the study is being conducted for the following reasons:

1. The employment of OQNs has been gradually increasing over the last five years, especially in rural health settings, with active recruitment of OQNs by the LHD (Ohr, Jeong, Parker, & McMillan, 2014).

2. The reports on 'incidents' involving OQNs have increased. These reports have been made by managers, ANs, doctors and patients, and

3. Minimal measures have been taken up to deal with these issues in the LHD.

1.2 **THE STIMULUS FOR THE STUDY**

In my capacity as both an OQN and a Multicultural Health Liaison Officer (MHLO) in HNE Health, I was aware of the issues outlined by Garling (2008). I have also been consulting with and supporting OQNs, ANs and health care facilities managers to deal with challenges and difficulties they face while working together in the LHD for over a decade. I am often asked to intervene when there are incidents and tensions in the workplace. OQNs and ANs have common concerns related to clinical practice, attitudes, uncertainty about each other and how to resolve issues. The ANs raised their concerns and frustration as well as resentment. They often say "We don't know whether OQNs understand what's going on"; "She/he does not say much at all"; "Can you help us to understand her?", "They don't understand the system", "Their English was not good enough for work", "Why do we have these nurses?", "It's a safety issue" and so on. On the other hand, OQNs also expressed concerns and voiced these through comments such as "I don't know what to say"; "No one wants to know us'; "They ignore us"; "If we don't answer right away, they turn their backs"; "They asked very silly questions like 'do you have this and that'- they treat us like we are from third world countries"; "Are we needed in this country?" Some OQNs have expressed

feelings of being unwelcome in the workplace and are often not empowered to try to find solutions. I have found that there is a need to address the concerns and issues for both ANs and OQNs to enhance their workplace experiences. However, I have felt that, merely being in a position of an OQN and a MHLO with requirements for responses and a "here and there approach" to achieve a quick fix for those challenges and difficulties has not always gone well. I realised that these issues and concerns may continue to exist unless a systematic approach to appropriate responses is taken. So I campaigned for an organisation-wide program to support OQNs and ANs and as well as the managers of the LHD.

Therefore, my purpose in undertaking this study was to establish a position from which to argue the importance of the establishment of this program for OQNs, ANs and managers. It was clear that the challenges and difficulties anecdotally identified by the OQNs, ANs and the managers in the LHD are matched with those identified by many international and Australian researchers over the last twenty years (Allan, Tschudin, & Horton, 2008; Brunero, Smith, & Bates, 2008; Cummins, 2009; Xu, 2007; Zhou et al., 2011). However, there remains an absence of systematic processes directed towards overcoming the tensions and problems experienced by both OQNs and local ANs in the workplace. I wanted to find out answers to the following questions:

- What are the experiences of the OQNs working with ANs in the LHD?
- What are the experiences of the ANs working with OQNs in the LHD?
- What strategies are in place to address these challenges and difficulties? and
- How do they (OQNs and ANs) work together within this LHD?

In addition, it was clear to me that inequality and power relations existed in the experiences of those challenges and difficulties among OQNs and ANs. This was evident through the complaints being made only against OQNs in the LHD, but not

against ANs, when both OQNs and ANs were involved. OQNs never voiced their concerns. There was generally an expectation by OQNs themselves, as well as ANs and managers, that OQNs needed to fit into the workplace, and then all those "problems" would be solved. Furthermore, it was evident that ANs also faced some challenges and difficulties. I felt that it was important to hear the stories from their perspectives as well. This led me to question, "How do OQNs and ANs work together in their work environment" and "What factors influence the way they work? These were two of the core questions that led to the study design for this research.

Ongoing efforts to establish a support program, including presentations drawn from the review of the literature of the experiences of OQNs were made to an audience of senior managers of the LHD and at a national conference. This led to the establishment of a program called "Overseas Staff Support Program". I was appointed to develop and coordinate the program in 2011. In that year, I undertook a study tour to the UK and USA supported by NSW Health, to explore international perspectives and experiences of integration of OQNs nurses. This study tour along with my personal experiences of global phenomenon of migration of nurses and of supporting both OQNs and ANs confirmed my conclusion that there is a need to investigate how OQNs and ANs work together in the workplace. I strongly believed that the situation was unsatisfactory, a source of dissatisfaction and one that was unhelpful for both OQNs and ANs and that there was a need for change.

1.3 **RESEARCH QUESTIONS AND AIMS**

This study focuses on how OQNs and ANs work together in an Australian health care system. The research questions addressed in this study are:

1. What is the nature of the context and experiences of OQNs and ANs working together in regional hospitals in Australia?

2. What support strategies are available to nurses in their working environment that promote a culture of reciprocity and collaborative working relationships?

3. Is there any congruence between the intentions and the expectations of the professional and organisational bodies towards the nurses as RNs in nursing practice and the outcomes that are construed from the experiences of the nurses at work?

The aims of this research were to:

- To explore the experiences of OQNs and ANs working together in a health care organisation, specifically a regional LHD in NSW
- To provide a mechanism to articulate nurses' own perspectives of factors contributing to their experiences
- To explore the practices and underlying mindsets that both groups of nurses employ while working together
- To identify support strategies for nurses in their working environment, and
- To compare the intentions and the expectations of the professional and organisational bodies towards RNs in the nursing practice and the outcomes that are construed from the experiences of the nurses while they work together in the Australian nursing practice context.

These questions were investigated through the lens of Critical Social Theory but with an emphasis on practical solutions achieved through an Interpretive Descriptive approach to the study design and data analysis.

1.4 **SIGNIFICANCE OF STUDY**

Recruitment of OQNs continues primarily to overcome workforce shortages and to establish a multicultural workforce (Buchan, 2009b; Health Workforce Australia, 2012;

NSW Government, 2008). The recruitment of OQNs is further encouraged by changes in policies and regulations, for example, the increased nursing hours per patient day in the Public Health System Nurses' and Midwives' (State) Award 2011. The dependence of the Australian healthcare system on OQNs has been recognised, along with a prediction of a continuous dependence of OQNs to meet the future Australian nursing workforce which is expected to have a shortfall of 109,000 nurses by 2025 (Health Workforce Australia, 2012).

As briefly discussed in Section 1.3, the dynamics of OQNs and ANs working together has created great concern for individual nurses' well-being and the provision of health care to the Australian population. With increased recruitment, the identified challenges and their consequences will continue to be experienced by OQNs, ANs and health care organisations unless they are addressed. This study attempts to build knowledge of nurses' experiences and suggest strategies to enhance cross-cultural experiences of OQNs and ANs in order to achieve reciprocal benefits for all concerned. In addressing an area of ongoing concern, the findings of this study will also inform policies and strategies related to OQNs and ANs and other health professionals within health care workforce in health care organisations and education organisations, as well as future research directions.

The study was undertaken at a crucial period of change in relation to the Australian nursing profession and immigration policy. It coincided with the following changes;

- Introduction of a National Register for Nurses in 2010
- Implementation of the National Standards on Nursing Competence Assessment for OQNs in 2010
- Development and introduction of support programs for OQNs as part of the Caring Together Plan 2009-2011, resulting from recommendations within the Garling Report (2008)

- Changes in the skilled immigration program, which may lead to preference being given to nurses educated in Australia (Department of Immigration and Citizenship (DIAC), 2009), together with plans to shift to employer sponsorship programs, whereby health services choose from those nurses on an eligibility list.
- A change in the nursing hours per patient day in the Public Health System Nurses' and Midwives' (State) Award 2011 may result in the recruitment of approximately an additional 1400 nurses over the next two and a half years across NSW.

To create a workplace environment that capitalises on strengths and provides equal opportunity for all nurses, it is important to understand the current experiences of all nurses. Such an understanding may inform the translation of policy to practice that both empowers and engages ANs (managers and clinicians) and OQNs. This study will be a vital foundation for the development of the overseas staff support program of the LHD to enhance the experiences of OQNs and ANs as well as the safety and quality of patient care provided by the nurses.

1.5 **THE KEY CONCEPTS OF THE STUDY**

Three key concepts, drawn from Critical Social Theory were identified as critical to informing the study; culture, difference and power. These concepts were also strongly evident in the literature that examined experiences of OQNs and cross-cultural working relationships amongst nurses. The current study aimed to gain insight into the ways that OQNs and ANs ‘‘live with’’ and “manage” culture, difference and power in their working lives. The concepts are closely linked and together provide insight into the experiences of study participants. It is important to recognise that any discussion about them is inherently sensitive because they are central to the nurses' identity and ways of working.

The first concept, culture, for the purposes of this study, is defined as “the integrated lifestyle, the learned and shared beliefs, values, worldviews, knowledge, artefacts, rules, and symbols that guide behaviour of a particular group of people” (Racher & Annis, 2007). This definition suggests culture impacts on perception, thought and behaviours in a way that they are re-created and interpreted in relation to the social realities around them. In other words, culture refers to the shared patterns of behaviours and interactions, cognitive constructs, and affective understanding which are learned through a process of socialisation (Arnold, 2003) and infiltrate all aspects of, in this case, the workplace and the nurses’ social interaction. With elements of culture learnt and shared by the members of the cultural group, culture of the nurses distinguishes them from any other category of people. However, culture is also changeable and not fixed in any precise way (Richardson, 2001). Further, critical discourse suggests that culture is important to understand how dominant and subordinate groups make sense of reality and that “culture is an ongoing political struggle around the meaning given to actions of people located within unbounded asymmetrical power relations” (Quantz, 1992, p. 483). In this sense, culture is constructed through social conditions together with people’s response to them; therefore it is within the larger context of history and material relations (Parker & McMillan, 2007). As such, culture is a way for a person to view the world, the organisations and professional bodies that operate and embody all aspects of working life. Hence, culture influences the individual nurses’ views, beliefs and behaviours at work. Culture is closely related to people’s identity, ways of life and their experiences. Without clarity and consistency in the understanding and application of the concept of culture, it is difficult to understand its impact on nurses as they come together in the workplace. Culture, in this study includes all aspects of interaction and is often expressed in terms of “the way things are done around here (McCormack et al., 2009). With elements of culture being learnt and shared by the members of the cultural group,

culture distinguishes OQNs and ANs from each other. Organisational or professional cultures represent the behaviours of people who are part of an organisation or a profession and the meanings behind the ways people react to the actions of others (McShane & Travaglione, 2007). These cultures include the values, visions, norms and rules, working language, systems, symbols, beliefs and habits of the organisation or the profession (Bloor & Dawson, 1994; McShane & Travaglione, 2007). Health organisations and the nursing profession also develop their own unique social and psychological environment and these organisational or professional cultures govern the ways that the health care organisation or nursing profession conduct their business and treat employees, customers/ patients, and the wider community (Bloor & Dawson, 1994). They also govern members of those organisations and professions and try to influence how they behave and act towards each other. Further, they influence to some extent decision making, personal expressions and attitudes to new ideas and how power and information flow through the hierarchy and the performance of individuals.

Organisational or professional cultures are developed by the interactions of their members in the process of conducting their professional duties. Socialisation of individuals into the workplace and the dynamics of cultural change in the hospital are equally impacting the culture changes of organisations and professions (McShane & Travaglione, 2007). Thus, individual nurses develop hybrid culture shared by them. In addition, the development and maintenance of professional and organisational culture of the nurses are working to ensure the safety and quality of care within a respectful and inclusive environment. The understanding and application of the concept of culture will contribute to the discussion about the impact of difference on the cross-cultural experiences of nurses within the nursing workplace.

Difference in this study is perceived as the differences between the individual nurses, differences between the nursing practices that the nurses hold, and differences in

cultural norms between different societies. These are closely related to differences discussed by critical theorists such as race, ethnicity, gender, class, education, ideologies and discourse, religion and other social institutions, and cultural dynamics interact to construct a social system as well as economic factors (Kincheloe, McLauren, & Steinberg, 2011). Critical theorists believe that these differences are forms of power and culture, and differences are played out by enacting power.

The last concept, power, for the purpose of this study is defined as "the ability of an individual or group to achieve their own goals or aims when others are trying to prevent them from realising them" (Merriam Webster Dictionary, 2013). Bourdieu, a critical theorist's concept of power is relevant as he believes that power is created culturally and symbolically and constantly re-legitimatised through an interplay of agency and structure (Bourdieu, 1991). To understand power in relation to social change in this study, cultural capital in the form of language, and nursing knowledge are emphasised.

These key concepts provide a framework for the study and a lens through which to explore the phenomenon. They also provide language to discuss the experiences as reported in Chapters Four and Five.

1.6 **STRUCTURE OF THE THESIS**

This thesis is presented in six chapters. This introductory chapter has discussed the background to the study, including the site where nurses from different cultures and backgrounds are working together. A critical review of the literature regarding the experiences of the OQNs and ANs is provided in Chapter Two.

Chapter Three provides a discussion of the theoretical framework of Interpretive Description underpinned by Critical Social Theory to inform the study to address the research questions. The study setting, recruitment of study participants, and the

approach to data collection and analysis are described. The chapter also includes a discussion of the relevant ethical considerations for the study.

Study findings are presented in Chapters Four and Five. Chapter Four provides an analysis of the documents, which identify expectations, and intentions of nurses in the Australian health care settings. Narratives connected to images that were offered by three nurses capture some of the experiences of being an OQN. They highlight how acculturation is achieved over time, and is incomplete and inconsistently experienced by different individuals. This chapter presents contextual factors that are intended to influence behaviours and thus experiences of all RNs working in Australia.

Chapter Five shifts the focus to the nurses' constructions of their working experiences as RNs in the Australian nursing practice context, and how they perceive themselves within the Australian nursing profession and as human beings. This chapter concludes with further aspects of context, culture and experiences as reported by nurses through interviews. The context, culture and experiences of nurses are presented through the dimensions: personal, professional, organisational and socio-cultural.

Chapter Six includes a discussion of the findings in relation to the existing literature. Conclusions are drawn about the extent of acculturation, acclimatisation and socialisation that has taken place for the study participants. It also addresses the implications for practice, education and suggestions for future research.

Chapter 2 **LITERATURE REVIEW**

2.1 **INTRODUCTION**

This literature review is grounded in the theoretical framework of Critical Social Theory. Based on this perspective, the literature is considered to reflect some of the broader social, cultural, historical and economic factors that may have shaped shared understandings within the culture, experiences (personal, professional, organisational, socio-cultural) and context of OQNs and ANs working together. The first part of the review aims to analyse the current situation on the movement of nurses in an international context as well as an Australian context from an historical perspective. This approach is taken with an assumption that the history of migration has a role in shaping taken–for–granted or accepted beliefs and perceptions and values of OQNs and ANs in the workplace. The second part of the literature review situates the study within the current body of research about the working experiences of OQNs and ANs. The review contributes to justifying the need for the study, highlighting the areas of focus and the gaps in the literature around the research topic, and seeking to identify the key concepts for the study.

2.2 **NURSE MIGRATION**

Migration of nurses is a global phenomenon (Buchan & Sochalski, 2004; Dumont & Zurn, 2007; Jones & Sherwood, 2014; Kingma, 2008; Kingma, 2009) that impacts significantly on the composition and character of nursing workforce internationally. The following section summarises and critiques the patterns of nurse migration internationally, as well as from an Australian perspective.

2.2.1 Global movement of labour and nursing workforce

There were approximately 232 million international migrants worldwide in 2013, an increase from 150 million in 2000. This represents the movement of 3.2% of the world population (United Nations Department of Economics and Social Affair & OECD, 2013). The United Nations further reports that 48% of these migrants are women, and that migration for labour occurs among less skilled workers who mainly are motivated to reduce poverty and to provide remittance of funds to their home countries. In fact, almost 414 billion dollars in remittance was sent by the migrants, mainly to the developing countries, in 2009 (International Organisation for Migration, 2011).

A substantial proportion (42%) of highly skilled workers is part of an interchange of professionals within the higher income countries (Organisation for Economic Co-operation and Development, 2010). It is reported that migration of skilled workers to member countries of the Organisation for Economic Co-operation and Development (OECD) has increased by more than 63% from 1990 to 2000 (Docquier & Marfouk, 2006). OQNs are a part of this globalisation of labour that is occurring consistently and in a dynamic manner.

In line with the global movement of labour, OQNs have moved from one country to another, often from developing to developed countries where the need for nurses has been apparent for some time. WHO estimates that there is a world-wide shortage of three quarter of a million health professionals, with 57 countries being in crisis (Organisation for Economic Co-operation and Development, 2010). Along with other health care professionals, the migration of OQNs has increased in many OECD countries, with the highest proportion of OQNs in Ireland (more than 45%), New Zealand (NZ) (22%), Australia (16%), the United Kingdom (UK) (8%), Canada (7%) and United States of America (USA) (3%) (Organisation for Economic Co-operation and Development, 2010). This has led to research, policy development, and

discussions worldwide, particularly in the USA, UK, Canada, Ireland and recently Australia, where the recruitment of OQNs is a widespread practice.

However, the recent economic crises and differences in international agreements have resulted in changes in the movement of labour. Some of the recipient countries like the UK and USA have restrictions on the recruitment of OQNs, and favour those from the certain countries. For example, OQNs from the European Union are preferred in the UK (Royal College of Nursing, 2015). Economic conditions in donor countries can also influence demand. For example, the economic downturn in Ireland reduced demand for OQNs, and potential migrants have been forced to move on to other countries like Australia where recruitment of OQNs is still active.

2.2.2 The Australian experience of nurse migration

Globalisation of the workforce more broadly is impacting on the Australia nursing workforce. OQNs were among the 129,200 skilled immigrants (68% of the total migrant intake) to arrive in Australia during 2014-2015 (Mason, 2013). The Australian nursing workforce is one of the most diverse workforces in the world. Only 72% of all employed nurses and midwives (213,491) were born in Australia (Australian Institute of Health and Welfare, 2013). Recruitment of OQNs into the Australia nursing workforce has been for some time. With active recruitment of nurses, there has been more than a 60% increase in the number of overseas nurses coming to Australia from 2008 to 2009 and registered nurses represent the largest increase in the migration of any occupation (Department of Immigration and Citizenship (DIAC), 2009). OQNs come from many different countries. Traditionally, the largest groups of OQNs were born in the UK and Ireland (Negin, Rozea, Cloyd, & Martiniuk, 2013; Ohr et al., 2011). However, there have been changes in the countries from which OQNs come to Australia. According to an analysis of census data for overseas born health care workers (Negin et al., 2013), there has been an increase of 250%, or 5,956 nurses and midwives, born in South

Asia, with a particular increase in the number of Indian-born nurses from 1,503 to 6,200 (313% increase), and an increase in the number of Nepalese-born nurses from 144 to 1,088 (656% increase) from 2006 to 2011. In addition, there has been an increase of more than 80% in the numbers of Indonesian and Filipino nurses and midwives. Another group of OQNs are 2,735 nurses from sub-Saharan Africa working in Australia – an increase of 68.6%.

Australia is not only a recipient country for migrating nurses, but also a donor country as many Australian nurses are employed overseas. During 2006-2007, more than 2,800 Australian nurses left Australia for longer than 12 months (Council of Deans of Nursing & Midwifey Australia & New Zealand (CDNM), 2009). The key destinations for Australian nurses are countries that make up of populations with an English speaking background (ESB), and where the education systems and nursing practices are similar to Australia. This bi-directional pattern of migration has been described as a “merry go round”, because many nurses from these countries have also migrated into the Australian nursing workforce (Buchan, 2009b). Numbers of Australian nurses working overseas or not in the nursing workforce for longer than 12 months have increased. In fact, there were estimates of 3,233 nurses who were overseas in 2009 and this figure increased to 10,166 in 2011. This adds a threat to the sustainability of the Australian nursing workforce. So nurse migration continues to be important for the future Australian nursing workforce as Health Workforce Australia (HWA) predicts dependence on the OQNs will continue to meet the shortfall of more than 109,000 nurses by 2025 (Health Workforce Australia, 2012) . Given the diversity in patterns and options for migration it is important to explore, the factors that contribute to both the migration of Australian nurses and the impact on workplaces of OQNs in Australia.

2.2.3 Contributing factors for nurse migration

The contributing factors for migration of nurses internationally may differ from one country to another or one nurse to another. A number of different “pull and push” factors have been identified in the literature (Kingma, 2006; Newton et al., 2012; Prescott & Nichter, 2014). These factors are linked to financial, professional, political, social and personal factors (Dywili, Bonner, & O'Brien, 2013), and are similar for nurses moving to Australia. This discussion centres on those factors with particular attention paid to the migration of nurses to or from Australia.

The three main reasons for the migration of nurses are 1) expectations for internationalisation and globalisation of healthcare, 2) situations within the local or the country of origin’s society, and 3) the specific needs of individual nurses. Patterns in internationalisation and globalisation, accelerated by faster transport, highly developed information technology, and International Trade Agreements like Free Trade Agreements (FTA), have affected the migration of people including nurses (Lawrence, 2008; Preston, 2009). Nurses are able to access worldwide information, to travel from one country to another, and to choose to provide nursing services for health care organisations around the world. For example, countries like the Philippines, India and China are purposely training nurses to export with an expectation for remittance income (Aiken, Buchan, Sochalski, & Powell, 2004; International Council of Nurses, 2007a). African nurses or any other nurses for that matter, are able to apply for employment in the UK via the Internet without leaving their home countries (Kingma, 2006). Under an agreement between the Australian and Korean governments, 50 Korean nurses migrated to work in the Queensland health care system in 2005 (Chung, 2006). The Australian Nursing Federation (ANF), the largest nursing industrial and professional body, over a decade ago, also indicated an acceptance of the FTA with China that facilitated the migration of nurses between the two countries (Australian

Nursing Federation, 2004). In addition, as noted above, globalisation has resulted in a record numbers of skilled Australians, including nurses leaving for NZ, UK, USA and other countries in 2008 (Evans, 2008).

There is a call for growing sufficient number of nurses in host countries (Buchan, 2009a) and an encouragement of the ethical recruitment of nurses from their country of origin, especially from developing countries and countries already experiencing a shortage of nurses themselves due to the loss of skilled workers (International Council of Nurses, 2007a; Sparacio, 2005). This is often referred to as a “brain and skills drain” (Kingma, 2009; Sparacio, 2005). While some have debated the validity of the recruitment of nurses as an ethical concern or a brain drain, others argue that migration of nurses is a personal choice (Buchan, Parkin, & Sochalski, 2003; International Council of Nurses, 2007a) and freedom of movement is recognised as part of the human rights that every person deserves (International Organisational of Migration, 2012; Lawrence, 2008).

While the migration of nurses is made easier by globalisation, it is also very much influenced by the local society and the nursing workforce. For example, the shifting of Australian immigration policies from an overarching philosophy of assimilation to one informed by multiculturalism, has facilitated increasing numbers of migrants to Australia. Consequently Australia is one of the most culturally and linguistically diverse global societies in the world (Kelaher & Manderson, 2000). In 2011, 48% of Australians were themselves born overseas or had parents born overseas (Australian Bureau of Statistics, 2013). Accordingly, the Australian government has encouraged large number of immigrants through policy setting and legislation, which promotes cultural and linguistic diversity. This has increased the number of qualified nurses migrating to Australia (Konno, 2006).

As Australia emerges as a multicultural society, a response by the Australian Government to meet the needs of a culturally and linguistically diverse Australian population was unavoidable. Various governmental workforce strategies have addressed the establishment of a multicultural health care workforce (NSW Government, 2008) . This contributes to the employment of health care professionals from different cultural and linguistic backgrounds, hence encourages nurses qualified overseas to migrate to Australia (Jeon & Chenoweth, 2007; Omeri, 2006).

Migration of nurses has been accelerated by the Australian Government's need to address the shortage of nurses in nursing workforce in Australia wide. One of these strategies was to include nurses on the "Migration Occupation in Demand List" to attract OQNs, especially the more experienced nurses, to migrate to Australia (Department of Immigration and Citizenship (DIAC), 2009). In addition, there have been statewide changes that encouraged the migration of nurses. For example, implementation of a change in the nursing hours per patient day in the Public Health System Nurses' and Midwives' (State) Award 2011 had the potential to result in the recruitment of an additional 1,400 nurses over the following two and a half years across the NSW (NSW Department of Health & NSW Nursing and Midwifery Association, 2009). This has provided an opportunity for increased recruitment of OQNs the NSW nursing workforce.

The promotion of international education as an export commodity in the local countries is also an important factor in the migration of nurses. Nurses from NESB countries, such as Korea and India have been encouraged to come to Australia to further their education. There is a large cohort of overseas nursing students in Australian universities. These overseas students made up around 18% of the 7,379 students who commenced nursing and midwifery courses in 2007. The majority of overseas students in pre-registration nursing and midwifery courses choose courses which prepare them

to seek employment and thus to remain in Australia after the completion of these courses (Council of Deans of Nursing & Midwifey Australia & New Zealand (CDNM), 2009).

The personal needs of individual nurses are also a major contributing factor in the decision to migrate. Four Australian studies, including 95 OQNs (44 from ESB and 49 from NESB), have identified various personal reasons given for migrating to Australia (Brunero et al., 2008; Kim, 2006; Konno, 2008; Takeno, 2010). Some factors reported included gaining professional experience, opportunities for career advancement, economic gain and personal safety. Migrant nurses believe there will be better working conditions and greater recognition of nursing as a profession in Australia than in their home countries. Although economic factors are the most commonly reported reason for migration but is never a primary driver of migration (Dywili et al., 2013). Some nurses have migrated in search of personal, political, and occupational safety. Many South African nurses migrate to Australia to escape from hazards such as HIV/AIDS and to escape from war. Similarly, nurses from South America, South Africa, Slovenia, former Yugoslavia, and China have migrated to Australia to escape from political unrest and danger (Konno, 2008).

The experience of migration influences individual nurses, the nursing and midwifery professions, the organisation within the Australian health care system and the members of the larger Australian society, many of whom will be patients. This will be discussed in the following.

2.2.4 The concerns of nurse migration

As discussed earlier, the migration of nurses contributed to the increased number of nurses in the Australian nursing workforce and to meeting the needs of diverse Australian population. Migration of nurses has also raised concerns about quality and

safety of care and impacted organisations' need to develop policies to guide processes of quality assurance. International nursing organisations have also raised a number of concerns. The concerns have been centred on retention and maintenance of nursing workforces in donor and recipient countries, recruitment processes being ethical, satisfactory working conditions and the welfare of OQNs in receiving countries. For example, a concern was related to unethical practices of recruitment agencies that might lead to behaviours that suggest some were "taking advantage" of OQNs, relying on their vulnerability in a new country through not being familiar with the recruitment process and not being familiar with 'reasonable' levels of payments and 'rewards' (International Council of Nurses, 2002; Kingma, 2006). The levels of support for nurses in a host country were also an issue. Dywili et al. (2013) insisted on the importance of advocating incentives to retain nurses in the donor countries and of increasing initiatives around socialization, implying the need for more innovative ways to mentor and orientate OQNs in the recipient countries.

Concerns led to investigations of migration flows, factors influencing migration and development of strategies for appropriate recruitment (Dywili et al., 2013; Kingma, 2006; Zurn, Dolea, & Stilwell, 2005). The International Council of Nurses (ICN) established a special group, the International Centre for Nurse Migration (ICNM), and developed recruitment policies and protocols to ensure the safety and security of migrant nurses and to network with agencies in all countries (International Council of Nurses, 2007b). The ICN has issued a statement to encourage ethical recruitment of nurses, and thus, countries like the UK and Australia are no longer actively recruiting nurses from developing countries. The WHO is monitoring the migration of nurses, especially the exodus of nurses from the donor countries, in particular developing countries (World Health Organisation, 2010). In line with these movements, individual countries have been working to situate the migration of nurses from their own

perspectives by developing their own policies, regulations, and programs to deal with migration of nurses.

The nursing professional bodies needed to develop a system to assess OQNs for their registration to practice in the countries of destination. Generally, OQNs, regardless of their host country, needed to meet five registration standards; identity assessment, fitness to practice, an English language requirement, competency–based nursing assessment and recency of practice (Australian Health Practitioner Regualtion Agency, 2016; Xu & He, 2012). To assess OQNs for their nursing competence, they are often required to do further courses to adjust to the standard of the elements of nursing competencies of the local nursing regulatory authority. For example, OQNs in the UK and Australia require attendance at transitional nursing courses of different lengths (Sherwood & Shaffer, 2014; Xu & He, 2012). In the USA, nurses qualified overseas need to pass the CGFNS Certification Program requirements and the NCLEX-RN® examination only in order to register (Xu & He, 2012).

For OQNs to practice as registered nurses in a new country, they would have successfully passed all registration requirements. However, the safety and quality of nursing care provided by OQNs is often in questioned (Sherwood & Shaffer, 2014; Xu, 2007).

With these concerns, a number of studies called for researchers, policy makers and industry and academic leaders to investigate the impact of globalisation on the nursing and health workforce (Jones & Sherwood, 2014; Ohr et al., 2011). In fact, many studies focused on details of the safety concerns and personal and professional experiences of OQNs in the host nursing workforces, and more broadly in society (Aboderin, 2007; Alexis & Vydelingum, 2004; Atack, Cruz, Maher, & Murphy, 2012; Bola, Driggers, Dunlap, & Ebersole, 2003; Brunero et al., 2008; Deegan & Simkin, 2010; Humphries, Brugha, & McGee, 2012; Konno, 2008; Negin et al., 2013; Omeri & Atkins, 2002;

Sparacio, 2005; Takeno, 2010; Xu, 2007; Zhou, Windsor, Coyer, & Theobald, 2010; Zizzo & Xu, 2009). Hence, this has been the topic of many reports in the literature including reports on discussions about experiences with the levels of diversity and complexity. In the following, the experiences of OQNs and local nurses are discussed in detail to justify why the current study is required.

2.3 THE EXPERIENCES OF OQNS AND LOCAL NURSES

As discussed, a large number of studies investigated the experiences of OQNs and local nurses. However, the overwhelming majority of studies used qualitative approaches to investigate the experiences of OQNs in local countries. The aims of studies were to “explore” or “describe’ or “understand” the different aspects of experiences of nurses especially OQNs. Therefore, existing studies aimed to increase knowledge of what is happening among nurses, particularity OQNs at work.

With the exception of two studies which investigated experiences of how they worked with OQNs in patient care (Blythe & Baumann, 2009; Flynn & Aiken, 2002), most studies including local nurses explored how to manage or assist OQNs in a new workplace. For this reason, local nurses included in studies were nurse teachers or preceptors (Deegan & Simkin, 2010; Gerrish & Griffith, 2004; Riden, Jacobs, & Marshall, 2014), policy makers and experts (Hunt, 2007), nursing leaders or managers (Gerrish & Griffith, 2004; Sherman & Eggenberger, 2008; Timilsina Bhandari, Xiao, & Belan, 2014) or a combination of these (Smith et al., 2007).

Regardless of different theoretical methodologies and sample characteristics, much of the literature suggests that the working experiences of OQNs and local nurses, to some extent, can be at times contentious, diverse and complex. The following are the themes from the literature review on actual shared experiences of nurses from different cultural backgrounds.

2.3.1 Perception of OQNs and ANs being together

Both positive and negative perceptions of OQNs and local nurses working together in a host country were identified in studies (Gerrish & Griffith, 2004; Jose, 2010; Josipovic, 2000; Sherman & Eggenberger, 2008; Xu et al., 2008). Literature suggests that OQNs thought of their working in the host country positively; OQNs reported having a better life in the host countries (Jose, 2010), better working conditions (Takeno, 2010) and high levels of satisfaction (Xu et al., 2008). Similarly, there were reports that local nurses recognised the contribution of OQNs to nursing practice. For example, 47 managers and mentors in three UK and the USA studies valued the contribution of OQNs in reducing the nursing vacancy lists and increasing diversity in workplaces (Gerrish & Griffith, 2004; Sherman & Eggenberger, 2008; Smith et al., 2007). They believed that OQNs contributed to high retention rates and that there were few disciplinary actions given their good personal employee attributes such as being hard working, loyal and willing to learn. They also reported that these positive experiences are the consequences of the successful transition to the new workplaces and overcoming the challenges and difficulties experienced by OQNs.

While there was evidence that the contributions of OQNs were received positively, others discussed OQNs working in a host country with perspectives on nursing competence of OQNs and the safety and quality of nursing care provision (Cummins, 2009; Riden et al., 2014; Xu et al., 2008; Zizzo & Xu, 2009). Some studies highlighted the OQNs' beliefs that they were proficient in providing safe and effective nursing practice (Edwards & Davis, 2006) or that they were "highly skilled" (Atack et al., 2012). Others reported OQNs as having a lack of competence in certain skills and knowledge. For example, an American study of the experiences of 10 nursing leaders working with OQNs, especially from China and India, reported that those nurses were less likely to act in an autonomous manner (Sherman & Eggenberger, 2008). Sherman &

Eggenberger (2007) also found that OQNs were not consistent in the use of stethoscopes in their practice to assess patient conditions and were having some difficulty in working in speciality areas like emergency departments or critical care units even if they have extensive prior critical care experiences. This suggests their prior experience might have involved different clientele with different acuity levels.

Further, Flynn & Aiken (2002) explained that their study with a sample of 547 American nurses and 252 nurses from 43 countries about the professional practice environments found that that there was no difference between American nurses and OQNs when the professional practice environment was examined closely (Flynn & Aiken, 2002). They concluded that this was different from their observation of local nurses' perception that the standards within the professional practice environment such as autonomy consistent with their responsibilities, control over patient care, collaborative relationships with physicians and working conditions, were undermined by having OQNs in the workplace.

As discussed, while the literature reports these concerns, there is lack of evidence suggesting clear links between the nursing practice and outcomes consistent with safety and quality of nursing care provision in the literature. Further, some authors reported on OQNs' feelings of distrust of the local nurses as they are consistently 'being watched' by local nurses and requested OQNs to adopt the host nursing practice (Holmes & Grech, 2015; Omeri, 2006).

2.3.2 A need for OQNs to adopt new nursing environment

Findings about nurses in previous studies found that there were many differences to address. With the identification of differences between the nursing practices that OQNs acquired during their original training and had practiced in their own countries of origin and the nursing practices that they needed to demonstrate in new nursing care

situations. Literature indicated that these differences were derived from different historical, political, cultural and socio-economic contexts within which nursing practices are situated (Xu, 2007; Yi & Jezewski, 2000). With these different contexts in nursing practices, other different professional values, role expectations and relationships with other health professionals and patients also contributed to expressions of difference (Takeno, 2010; Walters, 2008). Some of those identified by the OQNs and local nurses ranged from the uses of measurement systems, drugs and medical equipment to complex issues like different accreditation systems, documentation, procedures and policies and health care systems (Cummins, 2009; Konno, 2008; Xu, 2007). A grounded theory study involving interviews with 12 Korean nurses in the USA found orientations to nursing care and practices differ between Korean and American contexts (Yi & Jezewski, 2000). For example, participants suggested that Korean nurses' collective and hierarchical approach and US nurses' individualistic and egalitarian approaches to their work and their relationships influenced problem solving skills and interpersonal relationships among different nurses. Some other differences that were identified were related to health care environments and disease patterns such as refugee health and aboriginal health services, and services for multicultural community in Australia (Konno, 2008). Similarly, different cultural beliefs around death and dying were factors for the OQNs and local nurses in conflict, potentially impacting on patient care (Okougha & Tilki, 2010; Sherman & Eggenberger, 2008).These differences were contributing to the challenges and difficulties of OQNs when working in a host country (Hagey et al., 2001; Henry, 2007; Humphresis, 2009; Larsen, Allan, Bryan, & Smith, 2005; Likupe, 2006; Ohr et al., 2014; Okougha & Tilki, 2010; Omeri & Atkins, 2002; Takeno, 2010; Timilsina Bhandari et al., 2014; Walters, 2008; Xu, 2007; Yi & Jezewski, 2000).

With differences they identified are being "problems", a vast number of studies that report on experiences of OQNs and local nurses centre on a need for OQNs to adopt

the local nursing practices (Cummins, 2009; Jodan & Brown, 2011; Konno, 2008; Newton et al., 2012; Xu, 2007; Xu et al., 2008). They advocate that it is “OQNs” who “need” or who “want” to learn new ways of doing things and to unlearn their old way of doing things (Brunero et al., 2008; Cummins, 2009; Gerrish & Griffith, 2004; Konno, 2006; Xu et al., 2008; Zhou et al., 2011). Programs such as transition programs or Competence Assessment Programs designed to gain registration in the new country and in-service education and/or orientation programs for OQNs to transition to the new practice setting are readily available and implemented (Atack et al., 2012; Deegan & Simkin, 2010; Gerrish & Griffith, 2004; Jodan & Brown, 2011; Newton et al., 2012; Sherman & Eggenberger, 2008; Takeno, 2010; Zizzo & Xu, 2009) Holmes & Grech, 2014. While these measures are widely utilised, the studies identify different opinions about them; some report favourably on the efficacy of support transition programs (Holmes & Grech, 2015; Ohr et al., 2014), others report significant costs related to completing the programs for OQNs such as time, finances and stress (Gerrish & Griffith, 2004; Takeno, 2006). A survey with 251 OQNs in the UK concludes that more than 61% of respondents perceive no value adding to their transition into the UK nursing workforce as a result of completing an Overseas Nurses Program recommended for completion as a requirement to register in the UK (Jodan & Brown, 2011). As alerted by a systematic review of literature on the transitional programs by Zizzo and Xu (2009), there is a need to get more evidence on the efficacy of these strategies.

While there is inconsistency in findings about the efficacy of transition programs in the literature, it is still necessary for OQNs to adopt the new nursing practice given the governance framework of the profession in the country in which they have chosen to work. This suggests a need to explore the concept of the taken-for-granted ‘power over another’ about interpretation of learning needs and other expressions of imbalances of power among OQNs and local nurses. To some extent, OQNs are left without a choice

in the manner that they deal with the differences in nursing practices. This is reflected in an attitude of a 'taken-for-granted' deficit on the part of the OQNs and acknowledgement of the appropriateness of an imbalance of power at all hierarchy levels within the nursing workforce (Holmes & Grech, 2015; Omeri, 2006). Hunt (2007) describes this as the assimilationist approach and provides three reasons. First, this 'one way' direction in dealing with the differences in nursing practice suggests the host nursing practice is seen as 'given' (Hunt, 2007; Raghuram, 2007). Second, the author believes that this "taken-for–granted" favouring of the host nursing practice is due to both OQNs and local nurses idealising the host nursing practice as superior to those OQNs bring. The third reason is the sense of presence and power within groups of people of cultural difference (Hunt, 2007). Hunt is critical of this approach because it undermines the existing skills and competence of OQNs, lessens their self-worth and self–confidence as well as taking away opportunities for the local nurses to reshape their nursing practices in accordance with what they have learned from OQNs (Hunt, 2007; Raghuram, 2007). Xiao, Willis & Jeffers (2014) strongly suggest that two-way learning and adaptation in multicultural team can positively impact on the integration of OQNs in the new nursing environment. That means the need to adapt to a novel environment is not limited to OQNs as discussed in the literature, but also applies to local nurses. With the notion that OQNs are the ones to adapt in to the new nursing practice, there are limited strategies to assist local nurses to equip them to work with OQNs. There is scope to investigate how both OQNs and local nurses interact in the workplace, and to explore how they deal with their own situations that include cultural diversities and differences in nursing practices.

2.3.3 Challenges in communication and language

The literature has suggested that OQNs and local nurses experience challenges in communicating with each other (Clayton, Isaacs, & Ellender, 2014; Deegan & Simkin,

2010; Shen et al., 2012; Staples, 2015; Xu, 2007; Xu et al., 2008). The challenge of communication and language were identified among these most frequently discussed. For example, a meta-synthesis review of 14 qualitative studies (from the UK, USA and Ireland) found that communication and English language difficulties were one of the main themes among the lived experiences of Asian nurses working in western countries (Xu, 2007). Similarly, three studies, one with 12 Korean nurses, one with 9 Chinese nurses in the USA and one with 13 OQNs form NESBs and 4 local nurses in Australia support these findings (Deegan & Simkin, 2010; Timilsina Bhandari et al., 2014; Xu et al., 2008; Yi & Jezewski, 2000). It might be that communication is a vital element in nursing in all areas of activity and in working within a health care team in the provision of nursing care is achieved through dialogue, through interpersonal environment and with specific skills of verbal and written communication (Kourkouta & Papathanasiou, 2014).

The literature also identified a number of reasons for communication and language challenges. First, they were related to different language use and different uses of the English language in the workplace such as medical terminology, abbreviations, slang, jargon, and idioms (Konno, 2006; Xu et al., 2008; Xu & Kwak, 2007). Another reason was different use of non-verbal expressions for interpersonal interactions with health care professionals or patients (Omeri & Atkins, 2002; Xu et al., 2008; Yi & Jezewski, 2000). Further, some researchers suggested that challenges related to more complex reasons such as cultural values and norms in communication (Newton et al., 2012; Omeri & Atkins, 2002; Xu et al., 2008; Yi & Jezewski, 2000). They then emphasised that language was a part of culture that was lived and conveyed meanings to people within the culture. Therefore, understanding culture played a big part in OQNs improving their communication skills. Many studies emphasised the need for OQNs to improve their English in order to improve their communication skills in the work environment (Konno, 2006; Xu & He, 2012). However, this contention was not

supported by other studies, which stated that communication was influenced by more than those reasons identified above. The authors insisted that communication differed depending on the use of the different linguistics characteristics. An example, a study of the linguistic characteristics between 52 OQNs and 50 US nurses found that US nurses used particular lexico-grammatical features more frequently, including past tense and various stance features (e.g. certain adverbs such as ‘maybe’ and ‘kind of’) than the OQNs (Staples, 2015). The author concluded that linguistics characteristics played an important role in creating rapport with patients and providing more patient-centred interactions and contributed to nurses’ interactions with colleagues and patients. Hence, these differences were related to the development of rapport and working relationships. An Australian study of 14 OQNs in an operating theatre agreed with Staples’ saying that developing a sense of camaraderie and fostering good relationships between staff through regular social gatherings improved communication and the work atmosphere (Clayton et al., 2014). The relationship between communication and interpersonal relationships are described in the literature (Bach & Grant, 2009).

As discussed above, communication is one of the key aspects impacting on the relationship between OQNs and local nurses in the work place. While many studies direct OQNs to improve their English proficiency in the experiences of OQNs and local nurses, that may not be the only way to deal with the communication challenges.

2.3.4 Racism and discrimination

Racism and discrimination were identified as being experienced by OQNs in many studies irrespective of where they were conducted (Aboderin, 2007; Alexis & Vydelingum, 2004; Allan, 2010; Hagey et al., 2001; Likupe, 2006; Omeri, 2006; Xu, 2007). A survey of 1,119 OQNs in the UK (Market and Opinion Research International, 2002) and a focus group study with 67 OQNs (Allan, Cowie, & Smith, 2009; Allen &

Larsen, 2003) reported widespread practices of discrimination. Hagey et al. (2001), in an analysis of nine immigrant nurses in Canada, who filed grievances concerning their employer's discriminatory practices, showed that OQNs were being discriminated on the basis of OQNs being different from the local nurses and being cast as 'the other' due to their different colour, and/or simply being OQNs. Here, the authors pointed out that personal attributes were catalysts for discriminatory behaviour. A meth synthesis of lived experiences of immigrant Asian nurses working in western countries also reported marginalisation and discrimination (Xu, 2007). Racism and discrimination in the experiences of OQNs continue to be reported in recent studies, with two UK studies and two Australian studies reporting that OQNs from NESBs and especially those from African backgrounds were more likely to experience racism and discrimination (Alexis, 2015; Likupe, Baxter, Jogi, & Archibong, 2014; Mapedzahama, Rudge, West, & Perron, 2012; Timilsina Bhandari et al., 2014).

The impact of those practices on individual OQNs was to make them feel like victims, feeling hurt and losing self-worth (Allen & Larsen, 2003; Hagey et al., 2001). Other studies described how racism and discrimination were dealt with by OQNs (Hagey et al., 2001; Larsen, 2007; Turrittin, Hagey, Guruge, Collins, & Mitchell, 2002). Despite using only two participants, a UK study provided understanding of two different ways that OQNs dealt with discrimination and racism (Larsen, 2007). One female OQN accepted this as her fate, as part of life in the new country, while the other male OQN did not accept racist attitudes and behaviours. However, there are few studies involving nurses who were victims of discrimination and racism (Hagey et al., 2001). A Canadian study suggested that under-reporting of these practices occurs because of denial of racism by local nurses and/ or worrying about the reprisal or reprimands when a complaint or grievance was made (Turrittin et al., 2002).

Furthermore, some investigators focussed on the reasons for discrimination and racism. However, Henry (2007) claimed that reasons for discrimination and racism were institutionalised practices that undermined egalitarian formal procedures of career promotion for OQNs. Moreover, other authors argued that this approach could be a form of democratic racism which referred to as 'lip service' about equity and that this was a tokenistic approach to minimising the problem of racial discrimination in organisational practice (Allen & Larsen, 2003; Hagey et al., 2001). Woelfle & McCaffrey (2007) urged consideration of the view that discrimination and racism were part of horizontal violence that was frequently discussed when referring to relationships among nurses.

Regardless of the above argument, the literature suggests that racism and discrimination should not be allowed to exist among nurses due to the human rights of individual nurses. More importantly, working relationships have been shown to be affected by racism and discrimination and this is costly in relation to patient care outcomes (Hunt, 2007; Omeri, 2006). Therefore, some significant positive moves have been made by different organisations to improve the culture of the workplace, to achieve a respectful workplace. Some Australian examples of discouraging discrimination and racism and promoting respect within workplaces are the NSW Health's Code of Conduct and Zero Tolerance Policy (NSW Health, 2009) and Code of Professional Conduct of ANMC (Australian Nursing and Midwifery Accredication Council, 2008) in line with that from ICN (2012). These provide a framework for OQNs and local nurses to work within without resorting to discrimination and racism. However, a recent study of 14 skilled Black African nurses in Australia suggests that nurse-to-nurse racism exists in some form every day (Mapedzahama et al., 2012). These authors perceive that this everyday occurrence of racism is subtle but is being silenced. Therefore, there is a need to investigate if racism and discrimination is a

perception of OQNs or a reality by investigating the perspectives of OQNs and local nurses on their experiences of working together.

2.3.5 Being disengaged

The literature identified OQNs' feelings of being disengaged rather than engaged or included in the host countries. For example, some suggested that OQNs' experience being strangers and outsiders in their host countries (Konno, 2006; Newton et al., 2012; Omeri & Atkins, 2002; Xu, 2007; Zhou et al., 2011). Another study suggested that any move to a new place or a new society created major stress, therefore this was a normal state (Haslam, Jolanda, Postmes, & Haslam, 2008). The impact of such a move at a personal level was that OQNs were separated from family and friends and had to fit into new social groups through socialization. Walters (2008) explained that OQNs might not feel as though they belonged to the society they had left or the one they had entered at such times. In addition, two significant reviews of the experiences of OQNs identified that one of the themes of their review was OQNs "feeling like outsiders" at work (Konno, 2008; Newton et al., 2012). Konno suggested that the OQNs felt lonely and isolated in a new country and consistently saw themselves as "outsiders" in Australian nursing workplaces. Konno (2008, p.33) added description on "cultural incongruence" from "the experience of being set apart from the main group, a tension from different role expectation and cultural value, difficulty to form collegial relationships, and feeling of being a stranger at work" rather than being socialized into the new country and workplaces. Newton et al. (2012) also reported that cultural displacement exists in the experiences of OQNs and the reasons for that are communication and language differences, feelings of being an outsider and differences in nursing practice. Norton and Marks-Maran (2014) suggested a need to gain cultural sensitivity and insights by OQNs to ensure they were adequately prepared for the level of acclimatization and acculturation they would experience as part of the transition.

However, other literature explained this experience of disengagement differently. They insisted that disengagement was due to marginalisation and "Othering" practices in the work environment as the experiences of OQNs feeling like outsiders was not limited to the time or context of where they worked as an OQN (Magnusdottir, 2005; Omeri & Atkins, 2002). Although Omeri &Atkins (2002), Xu et al. (2008), and Magnusdottir (2005) conducted their studies with different samples and contexts (five OQNs in Australia, 9 Chinese nurses in America, and 11 OQNs in Iceland respectively), they found that OQNs' experiences of being marginalised and of being the 'other' on the basis of identity, ethnicity, experience and cultural differences. In the same way, all Asian nurses in a review of 14 studies have reported having felt "otherness' or a lack of a sense of belonging because of cultural incongruence between their own and the host culture (Xu, 2007). OQNs' feelings of being treated as marginalised and as "the other'. Not belonging in the same social fabric or not being part of "mainstream groups' can cause further problems coping with the challenges and difficulties they face. Xiao et al. (2014) agreed that unquestioned sub-group norms were barriers for group cohesion. With the reports of disengagement among OQNs, what was alarming was the report of the loss of self as a professional nurse that impacted on their psychological and mental well-being. As mentioned, being 'the other' is reported as a consistent struggle for OQNs in the host country. How this impacts on working relationships and patient care outcomes is not well known. However, the existing literature provides some insights into how this impacts on OQNs as a professional nurse within the host country.

2.3.6 Loss of "self" as a professional nurse

Within the literature there was evidence of OQNs experiencing loss of "self" as a professional nurse. Devaluating processes and feelings of invisibility were frequently mentioned as having impact on OQNs' professional identity (Alexis et al., 2007; Allen & Larsen, 2003; Deegan & Simkin, 2010). A UK study of 67 OQNs identified the lack of

respect towards OQNs (Allen & Larsen, 2003). A recent study depicted OQNs as having felt that they were being treated like children (Alexis & Shillingford, 2012). OQNs felt devalued by their situation, having to repeat nursing courses even if they were qualified nurses in their own countries, with some nurses having many years of nursing experience. By 'mismatching their experiences and their nursing skills', OQNs were often employed at a lower grade than they perceive reflects that of their experiences and qualifications (Gerrish & Griffith, 2004; Hunt, 2007) or as a 1st year nurse (Konno, 2008) or placed in an apparently less skilled area of nursing involving mainly custodial or basic care (Jeon & Chenoweth, 2007). A UK study of 40 overseas nurses, 8 managers and 15 UK nurses by O'Brien (2007) found that OQNs were prevented from using particular technical skills as these skills were seen as a part of the nurses' extended role in the UK nursing system. The study also suggested that UK nurses felt they were undermined by OQNs performing the technical skills. In addition, UK nurses felt threatened and criticized OQNs acting like "mini" doctors. While local nurses in the study still believed that OQNs should adopt the UK ways in nursing practice, those considered as reflecting the elements of core competence of UK nursing practice, OQNs believed that they have been deskilled when prevented from performing some technical skills (O'Brien, 2007).

Loss of a sense of self was connected to lack of opportunities for promotion, as well as feelings of being distrusted and of having "no rights" (Alexis et al., 2007), feeling devalued and unwelcome (Woelfle & McCaffrey, 2007). Aboderin (2007) demonstrated that all Nigerian nurses experienced a loss of professional and social status in the host country. Similarly, a phenomenological study focussing on 24 OQNs from NESB by Alexis et al. (2007) found that OQNs felt that they were invisible and being ignored when managers, colleagues, patients and families talked over them rather than to them, even if the topic of conversation concerned them. They claimed that valuing other colleagues was fundamental for effective teamwork and patient care, and could

lead to the harmonious environment being jeopardised, and the nurses being deprived of their rights as nurses without appreciating each other; tension and conflict thus occurred among nurses in the workplace. In a study by Zhou et al. (2011), 28 Chinese educated nurses reported struggling due to the differences and to form a new identity, reflecting and reconstructing the self, and reconciliation to adjust in the Australian nursing practice settings. Another study of 179 internationally educated physicians, nurses, and midwives and 70 federal, provincial and regional stakeholders in Canada concluded that the participants identify a process of professional socialisation (Neiterman & Bourgeault, 2015). In addition, an Australian study described how an OQN gained the satisfaction of ultimately appreciating the journey to finding her new home with a positive experience and academic achievement even if challenged along the way (Stankiewicz & O'Connor, 2014).

While the literature depicts concerns about differences and difficulties that OQNs, and to some extent, local nurses' experiences, the workplaces are those where the OQNs are working in the host country's health care settings. In the following discussion, the focus is on support as an influencing factor for transition of OQNs into the host country's nursing practice environment.

2.3.7 Support as an influencing factor

Literature on the experiences of OQNs and local nurses has suggested that there are poor working relationships between them (Nichols & Campbell, 2010) and lack of social and professional support from managers (Smith et al., 2007). Studies of the experiences of OQNs indicated that they perceived that local nurses were "not caring" and "lack team work" attributes (Alexis, 2009) and lack etiquette and professionalism (Smith, Fisher, & Mercer, 2011). Some of the reports in the literature suggested that different forms of support for OQNs were needed to help their transition; informal support and support from local nurses were also needed. Informal support from family,

friends, their colleagues and church were repeatedly discussed as coping mechanisms for OQNs by many researchers (Konno, 2008; Yi & Jezewski, 2000). In addition, the use of self-management skills involving elements of resilience and hope were also discussed within some studies (Hagey et al., 2001; Konno, 2008; Xu et al., 2008; Yi & Jezewski, 2000). Horenczyk (1997) also emphasised the importance of understanding attitudes of the local nurses as they developed policies and resource allocation to assist any immigrants, in this case, OQNs with adaptation and acculturation in the host country.

Support from local nurses in the transition of OQNs was considered important for socialization, acculturation and acclimatization to occur (Alexis & Vydelingum, 2004; Dreachslin, Hunt, & Sprainer, 2000). The local nurses' support was regarded highly in helping them to adjust to the new nursing practice, to improve their English skills, and be comforted (Hagey et al., 2001; Konno, 2008; Xu et al., 2008; Yi & Jezewski, 2000). However, as explained by a UK study by O'Brien and Ackroyd (2012), everyday racism inhibited "assimilation" processes of the OQNs into the UK nursing workforce. In addition, some studies identified lack of support measures for OQNs to assist their integration into the new nursing practice (Alexis & Shillingford, 2012; Konno, 2006), and asked for social and political action to support OQNs' socialization into the new contexts of practice (O'Brien & Ackroyd, 2012; Zhou et al., 2011). However, no literature focused on the experiences of local nurses within their work and their professional responsibilities to support OQN colleagues. An Australian study by Timilsina Bhandari et al. (2014) suggested that satisfaction levels of OQNs within their new nursing practice context depended on the provision of a supportive environment besides the development of skills in communication in English, interpersonal relationships, and salary and salary related benefits. Further, there were two different opinions about the nature of appropriate support in the literature. One qualitative study of three Korean nurses and two Japanese nurses by Takeno (2010) suggested that

support from local nurses was good. Another phenomenological study involving 24 OQNs from 11 non-English countries reached different conclusions, identifying a lack of support from local nurses as a consistent theme in the experience of OQNs (Konno, 2008). A UK study of 12 OQNs also stated that lack of support was a factor that impacted on the experiences of OQNs (Alexis & Vydelingum, 2004). In addition, the importance of supportive leadership was discussed as a prerequisite for effective transitioning of OQNs into their new workplace (Dreachslin et al., 2000; Hagey et al., 2001; Konno, 2006). Hagey et al. (2001) agreed that equal opportunity for access, inclusion and participation in all nursing sectors and on all levels were crucial factors for OQNs to overcome the challenges they faced as they attempted to achieve a high level of socialization and acclimatization into the norms of everyday life in a new country.

While local nurses' contributions to enhance the transition process of OQNs were discussed in the literature, some studies focused on preparing local nurses to support and work with OQNs, to assist with processes of acclimatization and acculturation. The strategies for local nurses discussed were cross cultural awareness training and the development of supportive leadership skills (Dreachslin et al., 2000; Hunt, 2007; Konno, 2008). Although there was limited literature focussing on the experiences of local nurses themselves, a study of 24 nursing leaders about working with OQNs, indicated that they were challenged by cultural differences and their own lack of preparation and training on how to best support OQNs (Smith et al., 2007). In fact, a NZ study by Riden et al. (2014) of 151 self-identified preceptors set out to establish whether preceptors believed they were adequately prepared to assess nurses for whom English was a second language. The findings indicated that they did not perceive they were equipped to perform such assessment. However, only a couple of studies reflected upon the local nurses' skills to work with OQNs in the host countries.

Consequently, there is a need to explore the experiences of local nurses while working with OQNs.

2.4 **DISCUSSION**

Migration of nurses will continue in the future given patterns in globalisation and predictions about future demands in countries recruiting OQNs. Both benefits and concerns about nurse migration, together with contexts of historical developments, political orientations, socio-cultural elements and expectations that nursing practice is culturally appropriate to the host country have been highlighted in the literature. However, it is still unclear what is happening when OQNs and local nurse's work together to provide patient care. There is also a need to find reasons underpinning experiences of OQNs and local nurses given the failure to do this previously; there is a need to employ a critical methodology that enhances understanding of the complex topic. For the purpose of this study, inclusion of local nurses and OQNs is pivotal to achievement of that comprehensive understanding.

With these complexities shaping the migration of nurses, the review of the existing theoretical and empirical studies on the experiences of OQNs and local nurses has also produced three key findings that are important for the current study.

First, the reports on experiences of OQNs and local nurses in host nursing practice settings are both positive and negative. However, it seems that the reports on positive experiences are far outweighed by the difficulties and challenges experienced by OQNs and to some extent those of the local nurses. Some studies also explain that the nurses from both sides of the equation have experienced those difficulties and challenges, but perhaps for OQNs, they are intensified by feelings of being marginalised, being treated as the outsiders and often targeted for discrimination and racism resulting in disengagement and loss of their identity personally and

professionally. Many studies focus on the experiences of OQNs in the host country's' nursing practice context. The reports on these experiences may represent one-side of the story. As suggested by Wheeler et al. (2013), the experiences of OQNs in the new work environment may be similar to that of the newly registered nurses within any workforce and their need for socialization and acclimatization to an unfamiliar suite of professional responsibilities. There are also additional challenges, such as adjusting to the attitudes of the local patients and their particular suites of symptoms of disease, the perceived lack of respect for nurses from different races and cultures and a need to adjust to different models of nursing care within organisational environments that differ greatly from those within their countries of origin.

Second, regardless of the reports of different experiences, there is evidence that alert the profession of nursing to experiences of transition among different OQNs and local nurses and the notion that these are dynamic in nature and complex. One explanation suggested that the transition process is not a linear movement from early negative experiences to more positive experiences as acclimatization and socialization progresses. The struggle to achieve a comfortable state but live with the existing ambivalence was evident in reports of nurses' experiences (Neiterman & Bourgeault, 2015; Zhou et al., 2010). There is lack of evidence on the transition within the working experiences of both OQNs and local nurses, therefore a call for an investigation of their experiences of working together.

Third, the experiences of OQNs and local nurses are discussed within the context of individual nurses' wellbeing, nursing workforce maintenance and retention, and the safety and quality of health care provision. Further, findings from studies suggest that the cause for the difficulties and challenges experienced by the OQNs, local nurses, the health care organisations are attributed to differences of culture, nursing practice, and language and their education and experiences of interactions between nurses from

different backgrounds. However, the responsibility to fix the problems is predominantly placed in the hands of the OQNs. Many studies indicate that there is a belief of both OQNs and local nurses, that assimilation into their new environment improves the quality of OQNs ' experience in the host country, improves their retention rates and thus improves the quality of care delivery within the host health care system (Xu, 2007). As OQNs, being part of a minority, the ways of the majority require them to adopt the nursing practices of the dominant group's language, culture and values.

On the other hand, other studies question the notion of being assimilated into their 'new environment, rather than requesting a 'rethink' about integration policies and practices (Hunt, 2007; Raghuram, 2007). Further, in agreeing with Zhou et al. (2011), other reports within the literature assert that negative meanings are ascribed to differences and those differences are used to legitimise inequality and hold the potential to perpetuate racism. It seems problematic to conceptualise differences as individual attributes without considering a complex and socially constructed concept within the Australian social and political context. Integration, by contrast to assimilation, requires acceptance of differences, human rights, fair treatment, and basic rights with keeping their own identify and cultural differences. This is a two way process that is suggested by some authors (Hunt, 2007; Raghuram, 2007). This two-way process will enhance local nurses as members of the majority group, and OQNs as members of the minorities to influence and to adapt to one another. Differences can be peacefully accommodated as long is there a common commitment to working together. This should be considered with recognition of migration as one of factors within the nursing sector and a rethinking of assimilation practices. However, there seems that there is no literature on the experiences of local nurse in this process; therefore, this deficit highlights a need for greater exploration of such topics among nurses within the clinical nursing workforce, the wider nursing profession and in the wider society along with consideration of individual attributes that affect experiences of socialization,

acclimatization and acculturation. Therefore, believing that making nurses, particularly OQNs, adapt entirely to the new nursing practice or new environment may transform the situation, might overlook the value adding that their prior experience offers.

As discussed above, this review has increased the researcher's understanding of the experiences of OQNs and local nurses at work and has elaborated on some of shortcomings in her original assumptions and her study aims. The review has identified gaps in the research to hand about the experiences of both the OQNs and the members of the profession within their new country. There are a number of important points to add to my conceptualization of the planned study.

First, there were limited studies that investigated the experiences of OQNs and local nurses while 'working together'. The majority of studies have described one side of the situation that of OQNs especially those from NSEB countries. The reports on these experiences neglect the contributions and experiences of the members of the 'other side'. Further reports on the loss of local nurses and OQNs from ESB are not well researched. With the limited opportunities of the local nurses to voice their thoughts and perceptions on working with OQNs in their daily work, this element of neglect has resulted in fragmented understandings of the experiences of OQNs and local nurses in a working environment reported on from their own perspectives. Second, there is a need to examine how the identified challenges and difficulties shape the experiences of OQNs and local nurses and the impact on the nursing care provision. In addition, the experiences of the OQNs and local nurses have been conveyed with an absence of criticism about contextual issues, ideology, for example, the conceptualization of expectations for assimilation versus integration, and elements of social control that impact on experiences of those being controlled. Therefore, with few exceptions, the current literature has been silent on matters such as inequalities, imbalances of power, marginalisation and discriminatory experiences of OQNs. Instead, there has been a

pervasive tendency to focus on the otherness and/or culture of OQNs as a barrier or negative influence that emphasises their differences. The connections amongst elements of culture, power and equality, otherness and identity or belongingness have received little attention to date. This study, using a critical methodology that focuses on interpretation of the experiences of nurses in the clinical environment, may assist in the investigation of these aspects of this cross-cultural situation. The absence of knowledge on how OQNs and the local nurses are working together 'on the ground' may have blurred aspects of their experiences and endeavours to achieve appropriate support for socialization, acculturation and acclimatization. In addition, the inclusion of reports on experience from both stakeholder groups may ease the sense of an imbalance of power reported in the literature. A study designed to achieve a better understanding of the experiences of OQNs and the local nurses should lead to a better framework for responses in policies and practices that enlighten awareness of 'informed expectations' about competence to practice as a professional nurse in Australia. This in turn will ensure optimal and culturally appropriate expectations about culturally sensitive patient care.

2.5 **CONCLUSION**

This review of the literature summarised and critically analysed different aspects of the experiences of OQNs and local nurses, and the shortcomings of the existing studies. While migration of nurses offers benefits to the host nursing workforce with an increased number of nurses to provide patient care and personal benefits to the nurses individually, negative experiences outweigh positive experiences in the experiences of OQNs and local nurses in the host country's nursing practice.

The review has identified a gap in the current understandings of Australian multicultural nursing workforce, particularly on how nurses from different cultural backgrounds work together in the clinical environment. The experiences of OQNs and local nurses are

contained within a range of micro-level interactions between individual nurses; these interpersonal processes occur in a social context shaped by macro level structures which themselves reflect socio-cultural, personal, organisational and professional differences and similarities, equality or inequality, and elements of the 'otherness' shown in the review of the literature.

The review also suggests the need for scrutiny of documents informing expectations of current professional nursing practice in Australia. Reports on the experiences of both OQNs and local Australian nurses will add to the evidence available to inform policies and practice protocols to address the need for support of migrating nurses in an effort to minimise the challenges and difficulties, and to enhance their experiences of socialization, acclimatization and acculturation to novel contexts of practice.

Having demonstrated how prior research informs this current study, in the next chapter I will demonstrate how the research was conducted, justifying methods in accordance with the research question and the theoretical and methodological underpinnings of Critical Social theory and Interpretive Description.

Chapter 3 **METHODOLOGY AND METHODS**

3.1 **INTRODUCTION**

The purpose of this chapter is to explicate the methodological and theoretical context for the study and explain the procedures used to conduct the study. The methodological approach and choice of methods were guided by the research questions to explore how OQNs and ANs work together in an Australian health care setting. The overall purpose of this study was to investigate the experiences of nurses OQN and ANs and to establish knowledge that will enhance a safe and productive work environment.

The study purpose and research question implied the potential use of two relevant methodological and theoretical positions or lenses through which to conduct the study and interpret findings. The first was a practical position whereby it seemed important in the current contexts of migration and of the nursing profession to better appreciate the circumstances in which OQN and ANs coming together as peers, and the contextual factors that impact on their capacity to work together well to deliver good nursing care. Exploration and interpretation of these matters would inform tangible recommendations for change.

An underlying assumption of the study was that that there is often disharmony in the workplace arising from misunderstandings between OQNs and ANs and that this disharmony threatens the safety of patients and staff. Therefore, a second Critical lens seeks to explore the nature and causes of disharmony and possible ways in which it can be overcome.

In order to achieve these purposes, I drew on the approach to practice based research known as Interpretive Description (Thorne, 2008). Together with Critical Social Theory

as a means to understand conditions in the workplace, especially those reflecting inequity, in order to achieve a democratic, fair and satisfying social context for nurses from a range of cultures and countries working in culturally diverse workplaces.

3.2 **METHODOLOGICAL ORIENTATIONS**

As mentioned earlier, this study was guided by Thorne's work on Interpretive Description. In addition, the concepts underpinning Critical Social Theory have relevance for the study as they provide a particular critical lens to examine the reports of the experiences of the nurses, to pose suggestions about why the workplace influenced the experiences in particular ways and what the consequences were for the nurses and their patient care.

3.2.1 The applied practice lens - Interpretive Description

Interpretive Description is an approach that highlights 'interpretation', then takes inspiration from the formal interpretive hermeneutic tradition without immediately becoming a confirmed believer in what is being reported; interpretation provides a bridge between objective neutrality and abject clinical theorising in an effort to produce findings that are academically credible, but also imaginative and clinically practical (Thorne, 2008). This approach transfers "pure" description of the phenomenon being studied to 'interpretive description" by seeking to discover associations, relationships and patterns within the phenomena described. In this study, Interpretive Description was used in the interrogation of reports on how the OQNs and the ANs work together in Australian context. The researcher avoided simply describing the phenomenon verbatim from the data collected, but examined the inherent assumptions and the phenomena described through reflective critical thinking processes. Searching for underlying meanings that might further illuminate what is happening and developing a deeper appreciation about the 'Intentions' outlined in documents pertaining to the

profession of Nursing and what would ultimately be the ‘Outcomes’ is important even if they may not necessarily always be the optimal responses to situations by the nurses. The choice of this approach enhances the belief that the analysis of the phenomena is valued and applied to the context of the practice field with all of its inherent social, cultural, political and ideological complexities.

The use of Interpretive Description also influenced the development and use of the research question and any sub-elements. The research question/s should be expressed in such a way that the participants can articulate responses in a manner that leads the researcher to extend reports on findings beyond generic qualitative description. In addition, questions able to progress both matters of interpretation and explanation. Interpretive Description methodology faces difficulties similar to the traditional qualitative methodologies, for example, in sampling, data collection and data analysis. The researcher needs to work with a high level of awareness of the problems and issues, generating credible and defensible new knowledge in a form that is meaningful and relevant to the applied practice contexts (Thorne, 2008).

While there are some common features bounded by the same set of assumptions about human experiences and about the nature and production of knowledge pertaining to it, there are a number of core elements that underpin Interpretive Description. Interpretive Descriptive studies:

1) Are constructed in as naturalistic a context as possible in a manner that is respectful to the comfort and ethical rights of all participants;

2) Explicitly attend to the value of subjective and experiential knowledge as one of the fundamental sources of clinical insight;

3) Capitalise on human commonalities as well as individual expression of variance within a shared focus of interest;

4) Reflect issues that are not bounded by time and context, but attend carefully to the time and context within which the current expressions of issues are enacted;

5) Acknowledge a socially "constructed" element to human experiences that cannot be meaningfully separated from it's essential nature;

6) Recognise that, in the world of human experience, "reality" involves multiple constructed realities that may well be contradictory; and

7) Acknowledge an inseparable relationship between the knower and the known, such that the enquirer and the "object" of the inquiry interact to influence one another.

(Thorne, 2008, p. 74)

Interpretive Description will inform rich understanding of nurses' experiences and how those experiences relate to the expectations of the nursing profession and health care organisations in Australia. From this 'situated position', the researcher then examined the experience from a Critical Social Theory perspective asking, 'What are the consequences of the socially constructed experiences and how can these be understood and potentially overcome through examination of the use power and influence, particularly that which is culturally ascribed?'

3.2.2 Critical Social Theory and this study

In this section, I present details on how Critical Social Theory as an approach related to this study, its assumptions, and the application of some of core concepts related to the study. Critical Social Theory is a type of social theory oriented toward critiquing and changing society as a whole (Geuss, 1981). This approach is different from more traditional theory that aims for better understanding or explanation. Critical theories aim

to investigate issues beneath the surface of social life and uncover the assumptions that keep us from a full and true understanding of how the world works in the eyes of different people (Kincheloe et al., 2011). Critical Social Theory emphasises an investigative approach and thus needs to include its historical specificity (how it came to be at a specific point in time). The approach enables questions to be posed about all forms of knowledge because the theorists believe that all data are shaped by the context and by the individuals that produce them (Kincheloe et al., 2011). In this context, the critical research may contribute to better understanding, in the context of the empowerment of individuals, as critical inquiry attempts to confront the injustice of a particular society or people within the society. This is because critical theorists use a number of assumptions in their work as a form of a social or cultural criticism.

3.2.2.1 Assumptions of the Critical Theory

The elements of Critical Theory changed and evolved in its attempts to avoid too much specificity and production of blueprints of social political and epistemological beliefs. However, the critical theorists still shared the following assumptions:

1) That all thought is fundamentally mediated by power relations that are social and historically constructed;

2) That facts can never be isolated from the domain of values or removed from some form of ideological inscription;

3) That the relationship between concept and object, and between signifier and signified is never stable or fixed and often mediated;

4) Language is central to the formation of subjectively privileged oppression; subordinates accept their social status as natured, necessary or inevitable;

5) Certain groups in any society and particular societies are privileged over others and although the reasons for this privileging may vary widely, the

oppression that characterises contemporary societies is most forcefully reproduced when subordinates accept their social statues as natural, necessary, or inevitable;

6) Oppression has many faces, and focusing on only one at the expenses of others often eludes the interconnection among them; and

7) Mainstream research practices are generally implicated in the production of systems of class, race, and gender oppression.

(Kincheloe et al., 2011, p. 165)

With those assumptions in mind, one can see that there are a number of key concepts inherent in Critical Theory.

3.2.2.2 Challenges of difference in Critical Theory

The movement of labour from one country to another, together with globalisation, has resulted in increased differences and diversity within a society and development of the policies and practices to address challenges of this reality (Buchan & Sochalski, 2004). In examining reports on how OQNs and local nurses work together in the context of a host nursing practice in the existing literature, several differences have been found (Konno, 2006; Zhou et al., 2011). Some differences are the focus of the Critical Theorists such as race, gender, and class. Others are by-products of those differences mentioned by Critical Theorists, such as culture, language and nursing practice. These differences are identified through the experiences of nurses in the multicultural working environments) as factors for challenges and difficulties they face and they are required to be acclimatised and acculturated into the multicultural work environment. According to Bourdieu, a French Critical Theorist, these differences are forms of cultural capital (Bourdieu, 1986). Whoever holds cultural capital has power over the person who does not hold cultural capital.

Critical Theorists discuss a number of differences such as race, ethnicity, gender, class, education, ideologies and discourse about religion and other social institutions, and cultural dynamics that interact to construct a social system in which the differences are explicated as forms of power. This view is different from the more traditional notion that the economic factors alone dictate the nature of other aspects of human experiences (Kincheloe et al., 2011). They also believe that recognition of the differences informs power and the use of Critical Theory can guide greater appreciation of how power and justice find expression and the ways that differences lead to particular experiences of disempowerment. With this belief, critical theorists analyse competing power interests between different groups and individuals within a society. Critical enlightenment emerging from the use of critical theory in research uncovers these behaviours of the privileged or marginalised that have arisen due to particular social arrangements and the processes through which power plays operate. Critical Theorists see instrumental or technological rationality as a feature of oppression in a society, claiming that the method or question of “how to” is of more importance rather than the purpose or question of “why should”. This leads to the facts being more readily separated from values. With a view that individuals are rational and autonomous beings, Critical Theorists investigate the interplay various axes of power, libido, rationality and emotion (Kincheloe et al., 2011). This relates the psyche to socio-political realm; the desire can be socially constructed and used either for destructive and oppressive outcomes or for progressive and emancipatory outcomes. The researcher assuming this view will be able to critically examine the practices and underlying mindsets that both ANs and OQNs employ while working together, and how they are constructed and used.

3.2.2.3 Understating power in relation to ideology, language, and culture

Critical Theorists are concerned about the various and complex ways that power operates to dominate and shape consciousness. They recognise the importance of the ability to empower, to establish a critical democracy, and to engage marginalised people in the rethinking of their socio political role. The focus of the Critical Theories is the oppressive aspects of power, which involves hegemonic power, ideological power and linguistic/discursive power. These expressions of power cannot be separated from each other. Gramsci's notion of hegemony is the understanding of dominant power being exercised not only by the physical force but also through social psychological attempts to win subordinates' consent via cultural institutions such as the media, the schools and the family (Kincheloe & McLaren, 2000). This is a complex process, which is treated carefully on a case-by-case basis. Further, hegemonic consent is never completely established. Rather it is being constantly contested by various groups for different reasons.

Hegemony centres on the political, economic and cultural forms of power exerted by a dominant group over other groups. Bourdieu (1991, p. 6) also argued that institutions (establishment or social purpose) of power lie behind behaviour and cultural meanings that construct and limit choices, confer legitimacy and guide our daily routine. This power is symbolic in that it relies on shared beliefs and ways of expressing those beliefs. The hegemonic power is closely related to ideologies of the dominant groups that shape the reality of both the subordinate and the dominant. Ideological hegemony involves the cultural forms, the meanings, the rituals and the representations that lead to consent to the status quo and position them in a certain place within it.

Linguistic/discursive power is important for Critical Theorists. Language is not simply an instrument of communication (Bourdieu & Passeron, 1990). Language is not only describing the real world but linguistic descriptions are constructing the "real world'

through discourse to form regulations and dominations. Discursive practices set rules that decided the relations such as the topics, who can say the importance and the right or wrong. Experience is inter-subjective and narrated by dialogues that involves situations where bodies marked by the social, difference (gender, ethnicity and race) (Tedlock, 2011). In line with Bourdieu & Passeron (1990), linguistic competency also positions the OQNs and local nurses with different power and status as discussed in the literature.

Critical Theorists have argued that culture is important to understand how people in different positions make sense of their reality. Depending on the forms of knowledge in their cultural domain, one can attribute different meanings to the reality. This cultural pedagogy, which refers to the ways particular cultural groups produce particular hegemonic ways of seeing, can lead to the creation of different values, knowledge and identity. By exposing the process of cultural pedagogy to bring “a more just, democratic and egalitarian society”, the critical theorists make sense of the world of domination and oppression (Kincheloe & McLaren, 2000, p285).

Critical theorists also believe that one can gain power to control one’s own life in solidarity with a justice-oriented community through emancipation. Critical Theorists try to achieve autonomy and human agency, resulting in emancipation. Emancipation can be achieved by exposing the forces that prevent individuals and groups from shaping the decisions that crucially affect their lives. Furthermore, emancipation requires identifying the forces that shape who we are while respecting the differences (Kincheloe and McLaren, 2000). Through the possibility of emancipation, the OQNs and the ANs for this study may gain a sense of greater power to control their own lives by making decisions for a just and fair situation for the expression of ways of enacting nursing practice and identifying the factors that shape their experiences at work. In addition, the different expression of power could also promote a social change. In the

following section, the concept of social change espoused by Bourdieu that was used for this study is discussed.

3.2.2.4 Understanding power and social change

A Critical Theorist, Bourdieu believes that "power is created culturally and symbolically and constantly re-legitimatised through interplay of agency and structure" (Bourdieu & Passeron, 1990). To understand the power and social change, he has emphasised four concepts: 'Habitus', 'capital', 'field', and 'doxa'. The first concept, 'Habitus' is 'the way society becomes deposited in persons in the form of lasting dispositions, or trained capacities and structured propensities to think, feel and act in determinant ways, which then guide them' (Navarro, 2006, p. 16). Habitus or socialised norms or tendencies guide one's behaviour and thinking (Bourdieu & Passeron, 1990). Habitus is developed through socialisation and changing depending on the specific contexts and over time (Navarro 2006) without any conscious decision to adhere to the social norms.

A second concept related to power is 'capital', which includes social, cultural and symbolic assets as well as material assets. These forms of capital can be accumulated and transferred from one arena to another (Bourdieu, 1986). Cultural capital is important for societal power relations, as this 'provides the means for a non-economic form of domination and hierarchy, as classes distinguish themselves through taste' (Gaventa, 2003, p. 6). The shift from material to cultural and symbolic forms of capital is largely what hides the causes of inequality. Bourdieu described three forms of cultural capital, the Embodied State, Objectified state and the Institutionalised state. The accumulation of cultural capital in the embodied state exists in the form of culture and cultivation and a person personally must presuppose a process of embodiment such as a labour of inculcation and assimilation with costing time. Bourdieu (1986) also explains that cultural capital can be acquired but this varies in some extent depending on the period, the society, and the social class, in the absence of any deliberate

inculcation, and therefore quite unconsciously. Cultural capital as the objectified state is very closely related to the embedded state, they are objectified in material objects, and media, such as writings, paintings, monuments, instruments, etc., is transmissible in its materiality. However, while the ownership of the materials may be transmissible, what constitutes the precondition for specific appropriation is subject to the same laws of transmission of any other embodied capital, and thus can be acquired with time. The cultural capital in the institutionalised state means any cultural capital requires recognition by an institution. Academic qualifications as examples of the objectification of cultural capital is one way of neutralizing some of the properties it derives from the fact that, being embodied in a person the same as biological limits. Cultural capital as institute state different from the capital of the autodidact, that could be questioned at any time, or even the cultural capital of the courtier, academic qualifications are the cultural capital that academically sanctioned by legally guaranteed qualifications, formally independent of the person of their bearer. With the academic qualification of the nurses can confer on its holder a conventional, constant, legally guaranteed value with respect to culture, social alchemy produces a form of cultural capital, which has a relative autonomy vis-à-vis its bearer and even vis-à-vis the cultural capital he effectively possesses at a given moment in time. Therefore, the cultural capital with institute state can be recognised the power.

A third concept referred to as ‘fields’, relates to the various social and institutional arenas within which people express and reproduce their dispositions, and where they compete for the distribution of different kinds of capital (Gaventa, 2003, p. 6). A field is a network, structure or set of relationships that may be intellectual, religious, educational or cultural (Navarro, 2006, p. 18). People often experience power differently depending which field they are in at a given moment (Gaventa, 2003, p. 6), so context and environment are key influences on habitus.

A final important concept in Bourdieu's understanding of power is that of 'doxa', which is the combination of both orthodox and heterodox norms and beliefs – the unstated, taken-for-granted assumptions or 'common sense' behind the distinctions we make. Doxa happens when we 'forget the limits' that have given rise to unequal divisions in society: it is 'an adherence to relations of order which, because they structure inseparably both the real world and the thought world, are accepted as self-evident' (Bourdieu, 1984, p. 471).

I assumed that these concepts were important for the examination of how OQNs and ANs work in Australian context. The core concepts of the study, involving OQNs and ANs, were their education and experiences, the Australian context, contemporary nursing practice, the culture of nursing and Australian society, are all related to the concepts discussed by Bourdieu. For the investigation of how the OQNs and the ANs work together, I have chosen to utilise the 'critical' lens as there are readily apparent differences in the way the two groups experience and how power and justice are situated. Taking a critical perspective involves a depth of understanding of the concept of power expressed within Critical Theory and how it may be reflected and practised within the study group. These assumptions are relevant to the study, as I believed that the ways and the experiences of the OQNs and the ANs reflected to the other while working together are socio-culturally constructed and that power imbalances exist due to the differences between the characteristics of individuals within both groups.

3.2.3 Why Interpretive Description and Critical Social Theory?

As noted above, I considered different research methods to investigate how OQNs and ANs work together in an Australian health care context. Both positivist (quantitative) approaches and qualitative approaches were considered. As the study focused on the experience or description of lived experiences of OQNs and ANs while working in Australian health care setting, interpretive description approach was chosen. There are

a number of reasons. First, the review of literature indicated a gap in reports on the experiences of OQNs and ANs working 'together' in their workplaces; there is therefore a lack of evidence on such experiences: There is a need to consider their experiences within the nursing profession as well as socio-cultural, political, ideological context and through a deeper layer of understanding. So by employing the Interpretative Description approach, this study attempted to describe and interpret those contexts together with the sub-cultures underpinning experiences of OQNs and ANs, and through their experiences of each other. This was because the researcher acknowledged that experiences of nurses and their working environment are context bound. The use of Interpretive Description methodology includes an assumption that both OQNs and ANs are bound together by their nursing profession with caring roles and responsibility for provision of nursing care for their clients within their workplaces. In a similar way, Kirkham's study of the experiences of recently graduated registered nurses caring for patients from different cultures successfully utilised Interpretive Description as an approach to extract and interpret common patterns in the nurses' views within their practice contexts (Kirham, 1998).

By employing Critical Social Theory as a philosophical paradigm, the study could also investigate elements beyond the surface of behavioural patterns to interrogate the context, culture and experiences with a social and cultural critical lens given the intention to find a way of changing the current situation should that be deemed necessary. In addition, these approaches have the potential to embrace the context of contemporary Australian nursing practice that provides the nurses with options to inform the intentions about their work and future working environment.

In summary, Interpretive Description underpinned by Critical Social Theory informed the study design and the methods used to address the research question. The study aims linked to the design are now discussed.

3.3 **RESEARCH METHODS**

3.3.1 Study design

In this section, I describe the research methods used to collect data to answer the research question: "*How do overseas qualified nurses and Australian nurses work together in the Australian context?"* As described by Thorne (2008), the study design was influenced by the need to pay attention to the clinical context in which the experiences of nurses are enacted and by the practical goal of improving those experiences and in doing so improve the opportunity for provision of quality patient care. The researcher believed that Interpretive Description and Critical Social Theory approach could optimise interrogation of data sets that provide answers to the research questions for this study by not only asking participants about their experiences of working each other, but also asking them to reflect on why they think this was happening. These approaches would identify the factors that could have influenced their perceptions of their experiences, and what commonalities and differences existed. In the following section, details of the research methods are presented with research process in a flowchart (Appendix 1. Research Process Flowchart).

3.3.2 Research setting

The setting for this study was the Hunter New England Local Health District, NSW, Australia (hereafter referred to as the District or HNE Health). HNE Health is located in the state of NSW, with Newcastle being the largest city. It covers 130,000 km^2 (approximately the size of England) and spans 25 local government areas. Services are provided to a population of more than 870,000 people, which includes 4.4% of Indigenous people, 20% were born overseas and 18% of people speak approximately 60 different languages (Australian Bureau of Statistics, 2012).

HNE Health employs 15,500 staff including 1,500 medical officers and 8,000 nursing staff. At least 12% of its staff are from culturally and linguistically diverse backgrounds (Hunter New England Local Health District, 2014). Cultural and linguistic diversity among community members in HNE Health is relatively small compared to the Australian population of almost 48% of people born overseas or a parent born overseas. There are a total of 27 hospitals of different sizes, ten multipurpose services, more than 60 community health services and three mental health facilities and several additional inpatient and community mental health services as well as three public residential aged care facilities.

Participant recruitment was limited to the acute care settings in Newcastle region where most OQNs are employed.

3.3.3 Recruitment of participants

Purposive sampling was chosen as an appropriate method to achieve study aims. Purposive sampling is known as a valuable kind of sampling for a special situation in which an unusual group is being studied (Minichiello, Sullivan, Greenwood, & Axford, 2004; Patton, 2002; Schneider, Elliott, Beanland, LoBiondo-Wood, & Haber, 2003). Creswell (2007) also stated that purposive sampling is an appropriate method to select unique cases that are especially informative and locate all possible cases of highly difficult to reach populations. As Thorne (2008, p89) suggested, the researcher attempted to recruit nurses as reflecting ‘a certain kind of perspective built from an auditable set of angels of vision whose nature and boundaries’ the researcher could acknowledge and address; the sample should also be ‘representative’ to the population that the study intended. Two major reasons were identified for choosing this sampling method. The first was that names or locations of OQNs and ANs who held key positions and had special knowledge of the phenomenon under investigation were not readily available to the researcher. The second was to recruit a heterogeneous sample

(different country of origin) within a homogeneous group (shared commonality of being OQNs and working in HNE Health). A heterogeneous sample was beneficial to confirm or disconfirm the conditions in a contextual and intervening sense, while homogeneous groups of individuals could benefit subsequent theory development (Creswell, 2007). As Flick (2006) stated, different backgrounds of OQNs led to intensified dynamics in the topic so to examine more aspects or perspectives of the phenomena, the experiences of nurses including challenges and issues. Although there were limitations with this approach in terms of its ability to generalise to a wider population, it was assumed that this would provide rich data about the phenomena (Creswell, 2007; Talbot, 1995).

The nurses who met the following inclusion criteria were invited to participate in the study;

An Australian Nurse (one who had an initial nursing qualification from Australia) who:

- was trained/educated in Australia,
- identified as an Australian nurse, and
- who had experience of working with overseas-qualified nurses while working at an acute care facility in HNE Health.

An Overseas Qualified Nurse (one who had an initial qualification from a country other than Australia) who:

- was trained/educated and first registered in a country outside of Australia,
- identified as an overseas qualified nurse, and
- who had experience of working in an Australian health care context for at least six months full-time equivalent and was working in an acute care facility in HNE Health

Potential participants were invited to participate in the research using two approaches. The first was to invite participation through Clinical Nurse Educators (CNEs) and Multicultural Health Liaison Officers (MHLOs), who were able to identify OQNs in the workplace. I presented an overview of the study and explored their willingness to assist in identifying potential participants using the study inclusion criteria during meetings with MHLOs and CNEs. Once MHLOs and CNEs agreed to assist, packages containing an information statement (Appendix 2 Participant Information Sheet), consent form (Appendix 3 Participant Consent Form), and a pre-paid reply envelope were provided to them to distribute to potential participants. While some of the CNEs and MHLOs consented to assist, they were reluctant to contact potential participants saying they were busy or noting their own inability to meet the potential participants. This method was successful in recruiting two participants. The second approach was the use of a flyer (Appendix 4: Recruitment flyer) displayed in staff rooms at targeted facilities, to inform nurses of the study and to invite them to participate. Potential participants were asked to contact the CNEs or MHLOs in the facility or the research student if they required more information or wished to participate. A total of five ANs and eight OQNs were recruited from three facilities.

There were six OQNs for whom English is a second language. There were seven different countries of origin represented among the eight OQNs recruited. While there were seven white coloured nurses (five Australians, one American and one Englishman), there were also four Asians and one African nurse. Their original education levels varied from hospital-based training to university education; prior working experiences varied from one and half years to more than 40 years. The mean age was 36.7 years. All of them were female except one OQN. In addition, all of participants are Australian registered nurses who are currently working at an Australian health care system even if their original qualifications were acquired in overseas countries and Australia (Table 1).

Table 1: **Demographic characteristics of participants**

					Year of nursing registration			Clinical experiences	
Participant	**Country of birth**	**First language**	**Age**	**Nursing Education**	**Initial registration in Australia**	**Year of nursing registration in Australia**	**Length of stay in Australia**	**in overseas**	**in Australia**
01 Bonny	Australia	English	47	Hospital trained	1983	1983			30 years
02 Kate	Australia	English	60	Hospital trained	1970	1970		1years	39years
03 Jean	Australia	English	37	University	2009	2009			1.5 years
04 Kim	Australia	English	43	Hospital trained	1987	1987			22 years
05 Leah	Australia	English	42	Hospital trained	1988	1988			20 years
06 Dean	England	English	38	University	2006	2009	1.5 years	1.5years	1.5 years
07 Joyce	USA	English	28	University	1997	2002	5years	6 years	5 years
08 Nora	Zimbabwe	English	28	Hospital trained	2004	2005	3 years 9 months	2 years	3 years 10 months
09 Suji	India	Indian	38	Hospital trained	1996	2008	7 years 8 months	9 years	1 year 5 months
10 Harna	Korea	Korean	40	Nursing college	1990	2001	9 years	2 years	8 years
11 Bao	China	Chinese	31	Hospital trained	2001	2002	9 years	1 year	7 years
12 Soon Hee	Korea	Korean	31	Nursing college	2001	2003	10 years	less than a year	7 years
13 Michi	Japan	Japanese	42	Nursing college	1988	1996	13 years	7 years	12 years

3.3.4 Data collection

Data collection methods are meant to capture the social meanings and everyday activities of participants in naturally occurring settings (Thorne, 2008). Within this study multiple methods of data collection were employed to facilitate a relationship that allowed for a more personal and in-depth portrait of the informants and their community. Given the elements of cross cultural experience a workplace culture and context, it was necessary for the researcher to explore individual nurse's experiences as they engaged with each other in the Australian context. Hence the study aimed to shed light on the professional nursing practice environment in which they worked (the nature of their work, their perceptions of responsibilities and duties, policies about health care delivery and the Australian workplace and culture, aspects of ethical and legal parameters with which they need to comply). The factors affecting their interactions and their working experiences were of particular interest given the aim to understand the phenomenon of collaborative practice across cultures as a whole. It was necessary to gather multiple and diverse sources of evidence and try to understand the relationships between them and the nature and extent of professional socialisation and acculturation and issues relevant to the achievement of optimal patient care. Thorne also added the importance of using multiple data sources to reduce the likelihood of falling into the epistemological traps that any one data source might set for the study (Thorne, 2008). Therefore, data were collected using the following data sources:

1. Documents that are related to nurses' work
2. Individual interviews with eight OQNs and five ANs
3. Images and artefacts that interviewees brought to interview that help to explain their perceptions of the experiences of working with another from a different culture, and

4. The researcher's personal journal.

Data collection occurred from November 2009 through to December 2011.

3.3.4.1 Document analysis

Document analysis in both Interpretive Description and Critical Social Theory is conducted to provide a level of insight into the political, historical and socio-cultural context to identify the influences of particular policies, guidelines and professional standards on expectations about behaviours and relationships within the participant group. It also provides a detailed description of the expected cultural traits and influences that should be shared by the participating nurses (Patton, 2002). Bowen (2009) suggests the use of organisational and institutional documents to increase credibility by triangulating data in qualitative research.

Using documents as a data source requires some consideration. Thorne (2008), while agreeing that documents can provide the certain experiential health phenomena, advises on the need for careful and thoughtful analysis. Atkinson and Coffey (2011) also caution that some documents might not exactly mirror neutral, transparent reflections of organisational or occupational life with emphasis on the researcher to consider the limitations of using documents as a data source as they might not provide sufficient details to assist her/him to understand the nuances of the reports. Patton (2002) also highlights varying degrees of quality and completeness in documents. Further, some documents might not be accessed due to blocked access or the selection bias of the researcher (Bowen, 2009).

Nevertheless, the use of the documents as a source of data also provides a number of benefits. As suggested by Patton (2002), documents provide a rich source of information about organisations and programs. It is important to recognise the extent to which many social settings were self-documenting. In addition, the documents provide

a means of verifying whether proposed statements of intent of the organisation and institutes are met in real situations, therefore, the documents are worthy of consideration as a primary source of data (Thorne, 2008). Use of documents is also beneficial in terms of increased time efficiency, limited access, and cost effectiveness. Documents analysis adds value to other data sources for triangulation purpose. It reduces the impact of potential bias in interpretation of self-reporting and opinions expressed by participants at interview. Additionally, as documents are not easy to change and bear the exact names, references and the events, they provided a stable data set with exact chronology of events. Thus, the review of documents provided the context within which research participants operate.

In addition, appraisal of relevant documents enables the researcher to develop understanding of the research questions and phenomena that this study is undertaking and discover insights and meanings relevant to them. Smyth and Holmes (2005, p. 67) suggest that “cultural, political and economic conditions of actions generally explain system integrations: each is reflected as a source of power at the system level”, then details from the document analysis might increase the critical stance of this study by understanding the cultural aspects and the political and economic underpinnings of interviewees’ reports on how OQNs and ANs work within a common workplace. However, it is also important to select documents that fully convey the intentions against which one can judge the extent of outcomes achieved for the purpose of answering the study questions.

In an attempt to identify and locate documents the researcher took the following approach. First, the documents that were relevant to the research questions were identified and accessed from various sources. The collected documents then underwent content and thematic analysis as do the other data sources. Themes were extracted by using a whole document such as Code of Ethics and Australian Nursing

Standards for a Registered Nurse or a part of documents were used by identified by use of key words such as “culture” and “multicultural”.

The documents analysed in this study included documents that were intended to influence how the OQNs and ANs work in the Australian context at three sources: 1) within health care organisations, 2) as set down by Professional bodies, and 3) through policy frameworks within national and international organisations. Document analysis is not intended to present an appraisal of the historical nursing literature per se, rather to examine the expectations around the role of a registered nurse in the context of nursing practice; the statements about ethical and professional practice, the competency standards and scope of their practice. Analysis of relevant documents enabled the researcher to identify expectations of both the professional behaviours and conduct and the service environment in order to corroborate findings across the data sets to uncover the meanings, develop understanding and discover insights relevant to the research problem. This had the potential to reduce the impact of potential bias in interpretation of self-reporting and opinions expressed by participants at interview. For example, by reviewing the documents from different sources, different agencies and expectations that played the role in the workplace culture and context and the professional nursing workforce were identified. Documents from a Local Health District or Department of Ministry of Health were treated as the self-representation of the organisations, which were essential for nurses to understand how organisations intend their employees to work and how they work with/in them (Atkinson & Coffey, 2011). Examples included NSW Health and HNE Health policies and procedures, circulars, directives, Codes of Conduct, and the content and processes of orientation programs and education for ‘transition to the workforce’ programs. In addition, analysis of reports on incidents such as patient complaints related to OQNs and ANs in the workplace were included in the analysis.

Documents from professional bodies such as the International Council of Nurses and Australian Nurses and Midwifery Council were also an important data source that are intended to guide and influence the nature of the profession of nursing, hence impacting on the experiences and activities of participating nurses. As the nature of nurses' work were often communicated in documents, the researcher examined the mission statements of agencies, the purposes of the policies and guidelines outlined within documents, and interpreted the significance of each and relationships within and between these documents. These excerpts from documents about statements of intent around the expectations of professional Australian nurses (e.g. Codes of Professional Conduct and Ethics) were to be used to make judgments on interpretations about the experiences of nurses in the Australian nursing context and the way the ANs and OQNs work together in an Australian health care setting. Patterns of socialisation, approaches to acclimatisation and efforts to achieve a level of acculturation were explored in order to determine whether the intentions were feasible in the everyday practice environment where optimal care for patients ensures a safe environment and a positive outcome for patients.

Further, the use of different formal documents was meant to convey the intent to elevate practice and to ensure safe outcomes for those who receive care from nurses. The majority of the documents provided a detailed description of the expectations of the nurses in Australian society and international context. Some documents were intended to guide the management of diversity in the workplace and at a community level. In the nursing profession, this is in part dealt with at the global level by the international forums, which guide cross cultural differences and patterns of migration of nurses.

All documents were read as objective statements of fact, but also with acknowledgement that they were themselves socially and culturally constructed. In

examining a range of relevant documents, I considered the contexts of practice, the likelihood that OQNs and the ANs were experiencing a period in which acculturation and acclimatisation were necessary but might be different for individuals and for different contexts. I determined which of the key elements of relevant existing documents provided details on the optimal level of professional conduct, behaviours and attitudes expected of the nurses while working together in pursuit of safe and effective patient care. In doing so I acknowledged that the documents were constructed from a particular perspective, i.e. largely by policy makers, managers and educators. These professionals might also be embedded in a culture and organisational context that has historically been ethnocentric and directed towards the harmony and cohesive working relationships and environments without due critical engagement with possible barriers, tensions and complexity. Figure 4.1 illustrates the complex determinants of the nurses' work in the Australian health care system that is included in the document analysis.

Figure 1: Determinants of nurses' work practices in Australian health care

3.3.4.2 Interviews

In-depth interviews were conducted with eight OQNs and five ANs to gain better insight into the research topic. Interviews are known to be a most effective way for one to access the realities of the participants as they provide an understanding of the nature of phenomena under investigation by contextualising and situating the phenomena. They provide insights into the cultural frames people use to make sense of their experiences and their social worlds (Kvale & Brinkmann, 2009; Miller & Glassner, 2011; Patton, 2002; Thorne, 2008). Thorne asks the researcher to reconcile the relationship between subjective and objective knowledge, interview is one of better and more accessible ways to gain access to subjective knowledge, therefore, is beneficial to many human subjective experiences like the experiences of nurses in this study. Therefore, interviews enable the researcher to elicit the articulation of the experiences from actual activities that the OQNs and ANs took part in by asking them to describe events or examples as they remembered. Interviews were conducted by taking the following steps:

A protocol for interviews was developed guided by the umbrella research question with a list of sub-questions (Appendix 5 Protocol for Interviews). The questions were general, broad, comprehensive, and flexible; and were modified during the study. However, these questions were only used as a guide as this study used an in depth interview method. To improve my interview skills before entering the field, I practised interviews with supervisors using the interview protocol. Demographic data on participants were collected before the interview (Appendix 6 Demographic Information). A summary of demographic data was presented earlier in Section 3.4.3. Although the demographic data were meant to describe the participants, this data collection procedure was also beneficial for the researcher and the interviewees to establish a rapport as talking about themselves provided ‘a way into’ discussions about their work

life. This also helped to develop a supportive and open environment for communication during interviews. The researcher also asked about their willingness for further interviews if she/he needed clarification and about their wishes about receiving the transcripts of the interviews for personal review. This provided them with a sense of control over what was being researched and their contribution.

At the commencement of each interview, I explained the reason why I preferred to tape record the interviews. It was emphasised that having the interview tape would in no way compromise their rights to be free from harm or discomfort. They were informed that they could turn the recorder off at any time they wished. Tape recording of the interview removed the need for researcher to concentrate on keeping a hand written account of what was being told, so the interviewer was able to engage with the participants fully. I listened to the interviews and took notes on main themes and patterns. Then the tape records of interviews were transcribed.

Prior to and after each interview, a memo was written to describe experiences, hunches, learnings, and observed realities so to gain a thick description of the study being conducted. These descriptive and reflective memos were written from the time I started to contact the participants. Each memo included details on how the appointments were made, where we met, what the attitudes towards interviews were and the key impressions I received during the data collection procedures. They were written from my office or home before each interview and shortly afterwards each interview in a car or a seat in a park. This was to reduce recall limitations and any bias, and enhance interpretation of interview transcriptions.

While conducting interviews and analysing the data, I immersed myself in the participants' ways of thinking, modes of perception, encouraged them to begin thinking about their own thinking by asking questions such as "How did that make you feel?", "What would have caused that?", "Can you explain in more detail" and "Can you give

me an example?". This was an effort to see their reports more critically, to think at more critical level about interpretations (theirs and mine) and to recognise the forces that subtly shape their experiences (Alvesson & Skoldberg, 2012; Kincheloe et al., 2011). The interviews were conducted once only except in the case of one nurse's interview that required clarification of some topics the participant described. The interviews lasted from 25 minutes to 90 minutes excluding time to collect demographic data and to build rapport before the interviews.

3.3.4.3 Visual data

Use of visual data such as images, artefacts or photos has been an important qualitative method for collecting data to understand the phenomena (Banks, 2007; O'Reilly, 2009). As suggested by Prosser (2011), the visual data used in this study is not about the image itself but is more concerned with the perception and the meanings attributed to them. My initial intention was to collect visual data to reduce the reliance on English language by giving participants an opportunity to explain their experiences using other forms of expression rather than language alone. However, I soon realised that visual data was also a way of preserving the appearance of an event or a person or a metaphor of an experience that was closely associated with ideas or relationships.

Some participants had difficulty finding any visual data around their stories, two participants provided images and one brought along a book. They were able to visualise their stories by using them as a descriptive mechanism to express feelings and to reflect on their experiences of working with each other. The images also provided the participants and the researcher with a talking point to start with as well as a road to share vivid experiences of their working life. The images represented the journey of nurses while working with other nurses when used together with tape recording of interviews. They helped to understand the participants as they make statements about complex processes and situations of the study under investigation as

told by the saying, ‘a picture presents a thousand words’. Further, narratives of images provided the three of these participants the ability to reflect and grow from their experiences, by evoking memory about and from their experiences in personal, professional, organisational and both the Australian and overseas communities. Both the images and the interviews made more visible of the different parts or narratives of a story and enabled opportunity to explore different positions within a dynamic environment or situation.

3.3.4.4 The personal journal

Besides the field notes, the researcher journal was a source of data for this study. The journal included the ideas and reflections of the study to recognise the subjective nature of the study and to position the researcher within a questioning mindset about the researcher’s assumptions, feelings, and the impact of changes in perception during the study. Self-awareness regarding values biasing the work of the researcher was important for application of Critical Social Theory (Kincheloe et al., 2011). I kept a reflective journal of my own working relationships with the OQNs and the ANs as a colleague and a MHLO, and later as a nurse manager who assisted both OQNs and ANs especially nursing managers at HNE Health. Writing the journal also assisted me to consider ways in which any incidents occurring among OQNs and ANs reported, this, in turn, identified opportunities for further exploration of critical issues. Developing a list in the personal journal was useful for me to understand how OQNs and ANs work in an Australian Health care setting and to generate ideas by associations that I started with the experiences of nurses. Producing a growing and organized structure composed of key words and key images enabled me to organise data, identify key themes by exploring associations. Because of the large amount of association among data sets involved, this helped me to generate new ideas and associations that were not thought of before. Finally, I explored my value orientations and biases as I was the

researcher who had been an OQN and working in Australian health setting for more than 20 years before entering the field. This was to keep my subjectivity during the fieldwork. This increased reflexivity of the study as suggested by Creswell (2007) and Thorne (2008).

As multiple and diverse data were collected, I accumulated a large amount of data including interview transcripts, research journals, documents, and images. This enabled the triangulation of data to strengthen the validity of the study (Flick, 2004). I reviewed data immediately after the data collection phase and continued data management during the study period.

3.3.5 Data Analysis

As suggested by Interpretive Description, data analysis for this study took an analytic form that extended beyond the process of taking things apart and putting them back together (Thorne, 2008). The researcher tried to see beyond the obvious and find 'interpretive description outcomes - a meaningful, rigorous and satisfying set of findings' (Thorne, 2008, p 142). This intellectual process began with 'making sense of data' such as working from pieces to patterns, then from patterns to relationships by sorting, coding and clustering data, then working through a conceptual process of findings by comprehending, synthesizing, theorising and re-contextualising. Thorne (2008), using Morse's taxonomy of cognitive operation, believes that this process of data analysis is required to conceptualise data using the Interpretive Description approach as described in the following.

As noted above, analysis of data was undertaken on an ongoing basis from the commencement of the study design to data interpretation and deconstruction of the data. Early transcript for the individual interviews were to be coded by the researcher first then validated by the supervisors. Differences in perspectives between the

researcher and supervisors were then cross checked into codes and themes, and preceded to validate an overall interpretation of data.

Data analysis was guided by qualitative analysis (Pope, Ziebland, & Mays, 2000) and Thorne's interpretive Description analysis (2008) concurrently. Data analysis commenced under the guidance of the five stages for qualitative analysis. This includes *familiarisation of data*, *identifying a thematic framework, indexing systematically to all the data, charting* and *mapping and interpretation.* The first stage enables the researcher to become familiar with the data. Starting while collecting data assisted in getting to know the participants and transcribing in detail, line by line, and writing up the detailed descriptions of the interviewees and consideration of memos taken as 'reflective' field notes designed to increase recall later on. The transcripts were read and re-read numerous times.

The second stage centred on identifying a thematic framework, incorporating the intentions espoused in documents. The interview transcripts were coded (line by line and memo coding) into the NviVo program to detect emerging patterns. The patterns were then coded to identify categories, themes, and concepts illustrating the phenomenon under investigation. Data sets were then analysed together to illustrate the similarities and differences in experiences and to understand how context shaped experiences.

The third stage was to construct the relationships between the intentions and outcomes among the different groups of themes and categories.

The fourth stage, charting, allows the researcher to rearrange the data according to the appropriate part of the thematic framework to which they relate and form charts of each theme with entries for several respondents. This process assisted the researcher to involve a considerable amount of abstraction and synthesis. Then a final stage of analysis of mapping and interpretation was undertaken. The comparisons of the

intentions framed within the various documents, policies and guidelines provided a mechanism for a more critical stance to be employed through all different stages to examine the ways in which experiences are shaped by the tacit assumptions about nursing practices in Australia. Data analysis was proceeding with the attempt to identify particular ways that the experiences of the OQNs and ANs report working together.

Further, the conceptualisation processes suggested by Thorne (2008) were used. In the comprehending phase, the researcher attempted to learn everything possible about the settings or the experiences of the study participants by concentrating on passively absorbing everything remotely related to the situation being studied. This process was used to uncover deeper layers of understanding about the phenomena.

The second phase, synthesising cognitive processes, helped the researcher to merge various instances and events to describe typical or composite patterns within the data. The researcher needed to distinguish the significant and the insignificant, and variations within the patterns. The researcher de-contextualised the processes from the individual instances of experiences reported and extracted common features through synthesis by 'generating, manipulating speculation, verifying and falsifying elements within it, and selecting, revising, and discarding possibilities (Thorne, 2008, p166). The theorising process, third phase, explained as 'developing best guesses about explanations' by Thorne, was for the researcher to question data and to consider theories emerging around and on the findings. The last phase, re-contextualising was a step that the researcher articulates the synthesised into a form that was applicable to other settings and contexts by taking the theory developed from the data to the practice and by developing implications of the newly generated knowledge.

These processes are used to understand what is involved in the development of a rigorous conceptual work that shapes the final findings by employing the interpretive process, in line with the inductive knowledge development process to obtain a thematic

description of the study. Through this process, the researcher develops thematic description, which is “ordered and organised to reveal aspects that would have been obscured through any other presentation framework” (Thorne, 2008, p173).

Using qualitative analysis and Interpretive Description analysis, the researcher attempted to understand the experiences of the nurses in a range of situations and tried to capture the truthful essence of those experiences. This enhanced the likelihood that the reader could access the original intent, purpose, and passion within the nurses. This way of unpacking meaning facilitated the presentation of the stories in the way the nurses intended.

With realisation of the fact that there were a range of factors that influenced the journeys that nurses undertook when they worked with other nurses originally from different cultures, the interpretation of individual nurses’ experience were presented in four dimensions around ‘intentions and outcomes'. These dimensions were decided by reports that their journeys had a personal dimension, aspects of experience that centre on professional requirements, consideration of the impact of the organisational context as well the wider socio-cultural context, that was Australian society. So the following framework was used to represent the individual interpretive stories and the emergent shared themes across stories (Figure 2).

Figure 2: The interpretation of individual nurses’ experiences: shared dimensions around intentions and outcomes

3.3.6 Enhancing methodological rigour

Trustworthiness is important for critical studies to ensure methodological rigor in qualitative studies (Rolfe, 2006; Sandelowski, 1993; Thorne, 2008). It is difficult to come to a consensus on quality criteria for qualitative research, given that there is no unified body of theory, methodology or methods for qualitative research and the very idea of verification of the validity of qualitative research is open to question (Rolfe, 2006; Thorne, 2008). Flick (2006) suggests that a number of verification strategies for the research process to ascertain validity and reliability of the study. However, Sandelowski (1993) believes that 'trustworthiness' is more likely linked to the issues of validity in qualitative research. In the later, validity refers to the extent to which the research findings represent reality (Flick, 2006). Similar to Sandelowski (1993), Rolfe (2006) and Flick (2006), Thorne (2008, p.229) emphasises an appreciation of the credibility or qualitative research through demanding a reverence for the ambiguous zone of validity and 'probable truth' which refers to shared reality. She also warns the researcher to be aware that certain kinds of knowledge claims that appear to meet the truth criteria may not be proven to be true. With this in mind, the researchers should still search for truth standards. Like Thorne, Creswell (2007) addresses the issues of reliability and validity in qualitative research, identifying some critical areas in which error can occur in five areas. They include the status or position of the researcher, informant choices, the social context in which data are gathered, the definitions and delineations of the constructs and their relationships, and the methods of data gathering and analysis.

The researcher considered all of these five areas and maintained an audit trail to document the researcher's decisions, choices, and insights and assist her in demonstrating methodological rigour. Thorne (2008) also emphasised enhancing credibility in a qualitative research like an interpretive description study while including

the importance of judging the study theoretically, epistemologically and technically sound. She discusses a number of evaluation criteria such as epistemological integrity, representative credibility, analytic logic, interpretive authority and beyond evaluation such as moral defensibility, disciplinary relevance pragmatic obligation, contextual awareness, and probable truth. During the research process, I have been conscious of the methodological rigour with considering all elements to meet its' rigour as evidenced in the design, data collection, data analysis and implications of the study. I also attempted to understand how the value orientations and critical epistemology influenced the study at the same time. In addition, I was very conscious of the impact of my 'being in' the research process. This is discussed under Reflexivity.

3.3.6.1 Reflexivity

Reflexivity is a process of reflection throughout the research, from the design stage to writing up results, even in publication of the research findings (Alvesson & Skoldberg, 2012; Flick, 2006). As suggested by Roulston (2010), the researcher continues to examine both oneself as a researcher and the research relationship including one's assumptions and preconceptions, and how these affect reaching decisions in selecting and wording of questions and in relating to the research participants, and how the relationship dynamic responds to questions during the qualitative interviewing. The researcher attempted to be "self- disclosing" in the writing by acknowledging the impact of the findings to the researcher, on the participants and on the reader (Creswell, 2007, p178-179). In the following two major components of reflexivity evidenced in this study are presented; an awareness of self and cautions taken while interviewing individuals across cultures and boundaries.

3.3.6.2 Awareness of the self

Self-reflection, a principle underpinning Critical Social Theory was important in order to identify my values and beliefs and their strengths and weaknesses. I needed to do self-

checks and know about myself in relation to participants and to the community I studied (Mertens, 2009). I reflected on my procedures and practices throughout the research journey, recorded these in my research journal, and reflected on the findings of the study. This was in line with Thorne's assertion (2008) that a sound critique of qualitative research goes beyond the surface level of adherence to a set of evaluation criteria.

As a researcher in my own work workplace, I was required to participate in the working life of the OQNs and ANs being studied while maintaining sufficient cognitive distance so that I could perform my scientific work. That meant I was required to investigate the phenomena from the perspective of an insider (taking the emic perspective) and a being outsider (the etic perspective) to increase understanding of the perspectives of OQNs and the ANs. I am an OQN who has satisfied Australian registration requirements and have worked in the Australian health care system for almost two decades. This assisted me with greater insight from prior experience, the privilege of being both an "insider" and an "outsider". Tedlock (2000, p. 466) an ethnographer, explained this position as that of being a "bicultural insider and outsider". He also argued that being a "Native" ethnographer who has one's origin in non-European or non-western cultures and who shares a history of colonialism, or an economic relationship based upon subordination gives some degree of insider status and binary view or dual consciousness gave certain advantage in understanding oppressed people worldview, but does not automatically give the researcher "native consciousness".

There is a need for me to assume a role that bridges the gulf between self and the other by revealing both parties as valuable experienced subjects working to co-produce knowledge. Regardless of this assertion of being able to bridge the usual experiences and cultures, I sometimes felt like I was pressured to sit on the fence – a need to create

a personal boundary for both sides of any cultural divide. This prior experience also has the potential to cause both OQNs and ANs to assume that I share their views and understand events that occur while working in the environment. I had to make a consistent effort to encourage them to explain the details of what they were trying to say to me without creating the impression of shared understanding at the outset.

Despite knowledge of anecdotal data and some evidence of trends in the literature, it was important for me to pre-empt any bias or assumptions. For example, I tried to ensure that neither OQNs nor ANs were assigned to a particular role (victim or offender) in my interpretations of their working relationships. Rather, the focus needed to be on the fact that 1) both OQNs and ANs were working in the context of challenging environments due to various cultural exchanges when they first met, changes in patient profiles, and limited resources within the contemporary context of practice; 2) what was not known and to what extent the key concepts in Critical Social Theory played out in their work experiences and patient care processes and whether there were other concepts that may explain their current working relationships; and 3) acceptance that change is inevitable to ensure justice and equality for both OQNs and ANs, and more importantly for patients.

The notion of me being aware of being an “outsider” (assuming an etic perspective) and an insider (taking the emic perspective) was pivotal to a study examining how OQNs and ANs work in an Australian health care system. It was essential to maintain a critical stance along through ongoing reflective practice during the study process. This realisationhas increased the reflexivity within the study by critiquing my beliefs and actions (Pallatt, 2003).

3.3.6.3 Interviewing individuals across cultures and boundaries

This study was conducted with a belief that all individuals held different cultural values and beliefs, and individuals’ actions were bounded by professional, organisational and

societal culture and context. The differences resulted not only from the place they came from (ethnicity), but also from their social, educational and personal backgrounds. Therefore, all participants were from a culture that was different from mine. I was mindful of this when preparing for the interviews. As suggested by McConnell-Henry, James, Chapman, and Francis (2010), I made myself aware of the factors such as researcher's interviewing skills, preparedness, knowledge of culture, ability to establish rapport, communication skills and control processes. It was an advantage for me to develop rapport with participants and understand their working nature and to be aware of cultural differences.

As a registered nurse and MHLO I needed to avoid imposing any assumptions or stereotyping. I acknowledged that some participants would have a high level of anxiety, possibly due to self-consciousness of poor English proficiency, and a desire to please as suggested by McConnell-Henry et al. (2010). I needed to attempt to reduce their anxiety levels as much as I could and provide a comfortable relaxed atmosphere by conducting interviews in a place chosen by the participant if it did not compromise the interview and safety issues. I also needed to ensure confidentiality and voluntary participation before commencement of each interview. Participants from different cultural backgrounds held different values on responsiveness to interview situations. I felt that participants would only say what they thought I, as the interviewer, wanted to hear or what they thought appropriate to say in their judgments at times. I understood that this could have been an obstacle to obtaining information critical to answering the research questions. To avoid this, I needed to ensure the participants were fully informed of the aims and focus of the study by recapping on the information statement at the beginning of each interview and using appropriate questioning.

At interviews, I would possibly be seen as an OQN, a Korean nurse, a nurse manager who supported overseas staff and managers, that means an Australian Nurse, and a

MHLO who helped migrants in HNE Health. Therefore, the OQNs and the ANs all had potentially different perceptions of me, some might perceive me as different from them, or the others same as them. I was aware that this could cause selective discourse about information provided in the interviews and thus I needed to emphasise to them I was interviewing them as a student researcher who was investigating how the OQNs and ANs work together in this workplace. I again needed to remind them of the aims of study.

As discussed earlier, I encouraged the use of images with a means to provide the nurses to explain their experiences with less reliance on English language. Besides that, different strategies for successive communication such as non-verbal communication, repeating, simple and single questions each time, using a quiet environment, and focusing on the aims of interview were employed. In addition, I have shared some of basic experiences of being OQNs with participants of OQNs and of working experiences in Australian nursing practice with ANs during data collection. This enabled participants and I to establish common ground, thus, to gain their trust and to establish rapport with participants.

3.4 **ETHICAL CONSIDERATIONS**

The study was approved by the Human Research Ethics Committee of Local Health District and of the University of Newcastle prior to commencement of the data collection (Appendix 7). The following ethical issues were ensured; autonomy, voluntary participation, and privacy and confidentiality.

3.4.1 Autonomy/ voluntary participation and informed consent

Potential participants were invited to participate in the study by receiving the information statement and consent form from the CNEs and MHLOs or in response to a flyer displayed in their staff rooms. Participants were informed that their participation in

the study was voluntary, and that they had a right to decline or withdraw from the study at any time without giving a reason and any disadvantage to them.

3.4.2 Confidentiality and privacy

The study complied with the privacy legislation. Every effort was made to ensure privacy and confidentiality. The researcher ensured confidentiality and privacy of information received: for data relating to the interview, participants' names were stored in a separate password protected database at the researcher's workplace office and at the researcher's home. In order to maintain the participants' privacy, face - to - face interviews were conducted at a time and place chosen by the participants. All audio-interview data, transcriptions and images were strictly confidential and stored in a locked filing cabinet. Data entered on the computer were password protected and only accessible by members of the research team. All data were coded with an ID number and the list matching ID number and a list of participants' names and addresses and code number were kept in a separate locked filing cabinet. Completed consent forms were stored in a separate locked filing cabinet. In addition, all research staff (including members of the research team, the CNEs and MHLOs, and transcriber) were instructed that they were to comply with the rules of confidentiality related to this study. At the completion of the study all identifying information will be stored for five years and then destroyed as required by National Ethics Guidelines (National Health and Research Council, 2007). No identifying data was or will be used in any publication or conference presentation, or any documents derived for the research.

3.4.3 Safety of participants and the researcher

It was important to ensure the safety of participants and the researcher during interview. This is critical when the researcher conducted the interviews at an unfamiliar environment to participants and the researcher. Therefore, a safety check of the

environment was conducted prior to each interview. The checklist included the possession of dangerous weapons or animal such as guns or dogs at home. There were no concerns about the safety of the participants and the researcher during the data collection.

3.4.4 Feedback of results to participants

Participants were offered the opportunity to receive a summary report of the findings of the study upon request (Appendix 2 Participant Information Sheet).

3.5 CONCLUSION

This chapter has provided details of the methodology and methods appropriate to address the research aims and questions and study design. The chapter also provided details on ethics clearance processes, the research setting, recruitment of the participants, processes to collect and analyse the data, ways to enhance methodological rigour and reflexivity and ethical considerations for the researcher and participants in this study. Chapter 4 now presents the first part of the study findings, the Document Analysis and reports on the experiences through three images and artefacts provided by the nurses.

Chapter 4 **CONTEXTS OF NURSES' WORK: INFLUNECES AND INTERPRETATIONS**

4.1 **INTRODUCTION**

The previous chapters provided an overview on the background to the study, a critical review of the literature, the conceptual framework and the research methodology, design and methods used for the study. The findings of the study are presented in chapters Four and Five. Chapter Four provides details of the context that influences nurses' work; i) expectations and intentions of Australian Registered Nurses in the context of Australian health service provision detailing professional nursing conduct, safe practice, the professional culture, and behaviours and ii) images that depict any sense of how nurses perceive their cross cultural experience of actual practice.

At the commencement of the study, given my own experience as an OQN or working as a nurse in Australia and having been recently involved in assisting other OQNs and ANs to work together, I made the following assumptions about the nature of the expectations and experiences of both OQNs and ANs working together in the Australian practice settings:

- It could be that the existing policies and protocols put in place to enhance the working experiences of nurses have not been well implemented in HNELHD(Evidence of availability of policies and guidelines would be available in policy documents and evidence of the accessibility and usefulness could be sought from interviews depicting personal experiences).

- It could be that better facilitation of socialisation and acclimatisation of OQNs and ANs is necessary (Interviews and images would provide some insight into personal experiences).

- More work needs to be done on exploring the mindsets of nurses from different cultures while working together in health services (Images constructed by those with experiences of working across cultures and interviews depicting personal experiences would provide greater insight into their worldviews).
- It could be that nurses meet the expectations and intentions of Australian Registered Nurses while working together (Comparison of policies and guidelines and experiences of nurses depicted might arise in the interviews and from interpretation of images).

To appraise of these assumptions, a document analysis was completed; I believed that the use of different formal documents meant to convey the intent to elevate practice and to ensure safe outcomes for the people for whom the participating nurses provide care. The majority of the documents centre on guidelines that can be modified to the context of nurses' work. This review of documents provides an appraisal of the concepts and details of the processes, boundaries and expected standards for the study participants and other potential overseas-trained personnel who work in the context of a health service in Australia. They also provide a detailed description of the expectations of workplace and professional culture and behaviours. As explained in Chapter Three (Methodology and Methods) the documents chosen are those intended to guide the management of diversity in the workplace. In the following section, the document analysis provided details on expectations and intentions of nurses to promote a safe and quality patient care and culturally safe and appropriate work environment. The documents were also identified as resources for nurses to refer to in their workplace. The findings are presented in four themes depicted in Figure 3: 1) management of cultural and linguistic diversity in Australian society; 2) recruitment practices; 3) a competent workforce; and 4) building positive, safe and healthy work environments.

Figure 3: Intentions and expectations of nurses in Australian nursing practice

4.2 INTENTIONS AND EXPECTATIONS

4.2.1 Management of cultural and linguistic diversity in Australian society

The first theme demonstrated that nurses need to acknowledge that in Australian society there is a need to deal with features of cultural and linguistic diversity. Given the profile of Australian Society, cultural and linguistic diversity in daily working life is a reality; nurses need to be competent in managing activities across cultures and with a high level of appreciation of language differences across the world and locally. This is closely related to protecting the human rights of patients/consumers and carers, and their own rights as professionals and as human beings. This is a critical element of the

contemporary context of practice and one that will influence the experiences within which the nurses are situated in their nursing practice.

4.2.1.1 Culturally and linguistically diverse work environments

Working in culturally and linguistically diverse work environments is a reality for OQNs and the ANs. Within the multicultural Australian population, 48 % of all Australians (potential patients, health care providers and community members) were born overseas or at least one parent was born overseas (ABS, 2015). Over 300 separate ancestries were identified in the 2011 Census with English (36%), Australian (35%), Chinese (4%) and Indian (2%) being most commonly reported (Australian Bureau of Statistics, 2012). Christian religions are predominant in Australia; there have been increases in those reporting an affiliation to non-Christian religions such as Buddhism (accounting for 2.5% of the population), Islam (2.2%) and Hinduism (1.3%). About 81% of Australians aged five years and over, spoke only English at home while 2% did not speak English at all. The most common languages spoken at home (other than English) were Mandarin (1.7%), Italian (1.5%), Arabic (1.4%), Cantonese (1.3%) and Greek (1.3%).

Reflecting the Australian society, the health workforce is also diverse. A number of Australian health professionals, for example, 34.2% of doctors and 16% of Registered Nurses, completed their initial qualification outside of Australia (Australian Institute of Health and Welfare, 2011). The report of *Health Workforce 2015 - Doctors, Nurses and Midwives* indicates that the Australian health workforce is dependent on overseas-qualified nurses and midwives to address the nursing and midwifery shortage. In addition, the *HWA's Strategic Plan 2013-16 and 2013-2014 Work Plan* describe the improvement of efficiency of migration pathways as a strategy to build health workforce capacity. This provides evidence of the importance of the role of the overseas-qualified nurses and midwives within the Australian health workplace.

4.2.1.2 Cultural and linguistic competence

Given the level of diversity, the policies and other documents related to the professional nursing practice and the health care sectors accommodate guidance on how to deal with cultural and linguistic diversity in the Australian society and nursing workforce.

For Australian society a number of documents, such as *The People of Australia: Australia's Multicultural Policy, 2011* and *Multicultural NSW Legislation Amendment Bill 2014* which supersedes the *Community Relations Commission and Principles of Multiculturalism Act 2000*, promote tolerance of and guidelines to manage such diversity. Both the Multicultural Policy 2011 and *Multicultural NSW Legislation Amendment Bill 2014* state that cultural diversity is at the heart of the national identity and is intrinsic to our history and character. These components of legislation were developed as a guide for all people including ANs, OQNs, patients and other members of the Australian society. The following four key elements of the policy and legal frameworks were identified as those of greatest influence on how ANs and OQNs in the workplace within the Australian multicultural society:

- celebrate and value the cultural diversity including people from diverse backgrounds maintaining their own linguistic, religious and ancestral heritage;
- commit to a just, inclusive and socially cohesive society while sharing values governed by the rule of law within a democratic framework;
- promote an understanding and acceptance of diversity including respecting and making provision for the culture, language and religion of others within an Australian legal and institutional framework where English is the common language, and

- promote tolerance and anti-discrimination. As evidenced above, the documents suggest that respect for differences in culture, ethnicity, religions, and language is required.

These elements provide the background and guidance for the nurses to promote behaviour consistent with the maintenance of a respectful workplace regardless of the diversity in places of origin.

A number of different programs have been implemented by health organisations to manage diversity in the workplace. An example is the Workforce Diversity Program, which provides a snippet of how the Australian Government aims to manage diversity. The document sets out three goals; to raise awareness and increase commitment to workplace diversity across the department; to increase our efforts in attraction, recruitment and retention of a diverse workforce, and to provide a supportive working environment that meets the needs of a diverse workforce (Australian Government Department of Health, 2016).

Individual nurses are also asked to demonstrate competence in dealing with cultural and linguistic diversity. A recently revised ICN's position statement, *Cultural and Linguistic Competence* demonstrates the ICN's belief that clients have rights to culturally and clinically appropriate care delivery (International Council of Nurses, 2013). All nurses should be aware of the need for culturally and linguistically competence. The latter enables greater understanding of the need to respond effectively to the cultural and linguistic needs of clients, families and communities who access services in a health care setting. The ICN statement also requests that the provision of culturally and linguistically appropriate care should be a component of nursing practice that in turn should be in line with the professional Codes of Ethics, Nursing Practice Standards, legal frameworks or *United Nations Human Rights*

conventions. ICN also strongly supports the notion that nurses with linguistic competence should be able to communicate directly in the client's own language. As demonstrated, the current ICN position statement *Cultural and Linguistic Competence, 2013* endorsed the position of nurses to care for patients in a manner that acknowledges aspects of cultural and linguistic diversity. What is not specified in that statement is the need for inclusion of aspects of behaviours that reflect culturally and linguistically competent care towards their co-workers; it does however refer to the United Nations Human Rights, which are equally applicable to their co-workers. Further, The *Code of Conduct for Nurses in Australia* and ANMAC's national standards insist the nurses value the provision of quality nursing care, respect for self and others, the diversity of people, participation of informed decision-making, and a culture of safety. It would seem clear that nurses, as individuals within Australia are required to demonstrate adherence to this framework.

4.2.1.3 Protection of rights of individuals

The ICN's factsheet *Health and Human Rights 2009* states that everyone has the right to a standard of living adequate for their health and wellbeing, with health as one of the fundamental rights of every human being. It affirms that the need for nursing care is universal and unrestricted by differences such as nationality, race, colour, age, sex, politics or social status. The position statement *Nurses and Human Rights* insists the nurses' obligation to safeguard, respect and actively promote people's health rights at all times and in all places by providing adequate care and respecting patient rights. Overall, it declares that the patients have rights of health care, and that nurses are responsible to provide the health care to them, as a core element of the nursing culture.

Accreditation and National Safety and Quality Health Service (NSQHS) Standards focus on the rights of patients in Standard 2 *Partnering with consumers*. The Australian

Charter of Health Care Rights and Consumer Rights enforce this commitment to partnership in the Australian health system. It assures the community at large that all patients have the right to high quality and safe care by equal access to health care, commitment to human rights, and respect for cultural differences and the ways of life. Further to this, the patients have a right to be communicated with, to participate in decision-making and choice making, to privacy and to comment on their care and concerns. Nurses are not only required to protect the patients/consumers rights but also to protect their own rights as an individual and as a human being.

A number of documents are used to protect the rights of nurses. The Australian Human Rights Commission states that Australian law aims to protects all workers from discrimination and harassment in the workplace (The Australian Human Rights Commission, 2014). It is unlawful for an employer to take adverse action against an employee, such as termination, on the grounds of race, colour, sex, sexual preference, age, physical or mental disability, marital status, family or carer's responsibilities, pregnancy, religion, political opinion, national extraction or social origin. The Fair Work Online factsheets detail the mechanisms of protection of the members of workforce including nurses. The Australian Nursing and Midwifery Federation (ANMF) clearly suggest a number of protective mechanisms for the OQNs at work and from discrimination and harassment in that workplace (Australian Nursing and Midwifery Federation, 2015a).

4.2.2 International recruitment practices

International recruitment practice makes up another context, where nurses are ultimately situated for their work. The accepted international practice is one of the reasons for the preferences that OQNs make about where they might work across the world. Immigration policies assist both employers and employees to manage movement of personnel 'in and out' of the Australia. These recruitment practices are

informed by the development of the different recruitment policies and management processes.

4.2.2.1 Immigration policies

Immigration policies have been used as one of the ways for the Australian Government to manage the migration patterns of the workforce. These immigration policies also influence the nature and extent of the blended culture of the Australian society and attitudes of people; as immigration policies have been enforced and used within campaigns reflecting political intent and justification. For example, ideas about human difference, which shaped attitudes towards 'non-white' cultures during the 18th century and the debate on racial hierarchies with white men at the top of decision-making trees continued between the 1850s and 1900. These debates influenced the immigration policies and practices and thus the culture of Australian society (Department of Immigration and Border Protection, 2015). Today, there is no Bill of Rights in Australia and under the *Migration Act,* the Australian Government continues to control who come into Australia including workers from overseas. International and national politics and aspects of trends within social sciences have also influenced how Australian people and the society think and feel about those who have been considered different, inferior or threatening. The development of policies over particular timelines such as those outlined above, allow one to trace how particular patterns of beliefs and prejudices have affected who we are, how we govern and what we believe about membership of Australian society.

Qualified nurses are included in patterns of global migration. The entrance of overseas workers is controlled by the Department of Immigration and Border Protection (DIBP), with an Australian visa with work rights issued on either a temporary or permanent basis. The regulations surrounding work visas are very closely linked to the demands of the Australian workforce, clearly evidenced in the Australian and New Zealand

Standard Classification of the Occupation and criteria for visa applications. Besides the qualification and experiences of the profession, the DIBP includes age limits and an English proficiency as requirements for the visa. This systematic approach is aimed at increasing the productivity of people who enter Australia for possible work. Only selected workers approved by the DIBP are able to enter Australia to work, as evidenced in a DIBP statement "*Employing legal workers"*. DIBP also provides basic protections and entitlements, work rights, visa choices, employer obligations and use of a migration agent for recruitment of overseas workers to the Australian context (*Your rights and obligations-immigration facts for worker).* The Australian Nursing and Midwifery Accreditation Council (ANMAC) is the assessing authority for the DIBP for determination of the suitability of the qualifications of nurses and midwives. They have (or have developed) criteria for determining whether or not particular qualifications make them suitable for permanent migration or whether they need to undertake more education to become eligible to practise in Australia.

4.2.2.2 Ethical recruitment of nurses

While Australian immigration policies are impacting on nurses from countries outside Australia, nursing professional organisations are also influencing the migration of nurses. The International Centre on Nurse Migration (ICNM), an organisation within the ICN, with a fundamental principle of the ethical recruitment and equitable treatment of the migrant nurse, influences the international recruitment of nurses to particular countries. The position statement '*Ethical Nurse Recruitment'* provides the details the ICNM's expectations to protect the migrant nurses. In addition, ICN recognises the right of individual nurses to migrate, and confirms the potential beneficial outcomes of multicultural practice and learning opportunities supported by migration. In this position statement, ICNM insists on a number of underpinning principles for ethical recruitment (2007) that influences the practices in Australia, aiming for the maintenance of a fair and equitable treatment of OQNs. These international positions on the ethical

recruitment are supported by the Australian industrial unions such as Health Service Unions (HSU, *Code of Practice for the International Recruitment of Health Workers*, 2009) and NSW Ministry of Health (2015- includes PD).

4.2.2.3 Regulations and policies: recruitment of qualified nurses and midwives

A number of current documents support recruitment of nurses from overseas to Australia. Like the ICN's ethical overseas recruitment and World Health Organisation 2003 *International nurse mobility, trends and policy implications*, the Australian Nursing and Midwifery Federation endorsed overseas recruitment as a permanent part of the nursing workforce strategies (Australian Nursing and Midwifery Federation, 2015b) . The ANMF policy insists on the recognition of the OQN's previous experience and prior formal educational qualifications. In addition, the current NSWNMA policy on *Overseas Recruitment of Nurses and Midwives 2009*, similar to the ANMF statement, outlines its position on the recruitment of overseas-qualified nurses and midwives into Australia. Given the recognition by the NSWNMA of the skilled nursing workforce shortage in Australia, they welcome the migration of nurses and midwives. However, the Association also emphasises the need to grow domestic nurses and midwives. Such that, the policy asserts the recruitment of domestic applicants as the preferred choice when recruiting, however, an equitable, fair, non-discriminatory procedure for the assessment of overseas nursing qualifications the recognition of their prior learning and experiences and protection of the OQNs is encouraged.

4.2.3 A competent workforce

Provision of a competent workforce is a core element that affects nurses' work. A number of professionals and professional organisations influence Australian nursing practices and the nurses working within the system. They are responsible for guaranteeing a competent and confident workforce to provide safe care and minimise risks to health care consumers. Under this theme "competent workforce", there are five

different aspects of guidelines and policies, which influence registered nurses in Australia. These are nursing education, regulation of registration, national competency standards, professional conduct and codes, and pursuing excellence.

4.2.3.1 Nursing education to prepare the nurses

The achievement of a competent nursing workforce commences with nurse education that leads to an acceptable level of competence and confidence. ANMAC, as Australia's single independent accrediting authority for nursing and midwifery under the *National Registration and Accreditation Scheme (*the National Scheme*)*, plays a key role in protecting the health and safety of the Australian community. It aims to ensure high standards of nursing and midwifery education. It enforces the assurance mechanisms for maintenance of a culture of safety and quality in care. The latter should be central to the nursing culture. Education is critical for nurses who contribute to the ongoing development of members of the workforce. An aspiration for relevance and appropriateness in continuing education ensures nurses are aware of the necessity for a safe and culturally appropriate environment in which to work. It is expected that nurses and midwives will be (or are) prepared to work within the protocols and agreed standards by the nursing education institutions. The Australian College of Nursing and Midwifery (ACNM) also contributes to maintaining a competent workforce as a key national professional nursing organisation with a focus on leadership. It is also an authorised higher education provider, registered training organisation, and is a member organisation of the International Council of Nurses.

4.2.3.2 Regulation of nurse registration

To practise in the Australian nursing context, nurses need to register with the Australian Health Practitioner Regulation Agency (AHPRA). AHPRA was established under the National Registration and Accreditation Scheme (National Scheme) which was instituted by the Council of Australian Governments (COAG) in 2008 to assure the

public on the suitability for practice of all registered health practitioners. Accreditation under the *Health Practitioner Regulation National Law Act 1* (the National Law) has been developed by national boards of health professionals and the Australian Health Practitioner Regulation Agency (AHPRA) to provide information about accreditation, and hence is relevant in this instance guide the accreditation of nurses and midwives. The Nursing and Midwifery Board of Australia (National Board) within the AHPRA is the national regulator of nursing and midwifery in Australia and has an important role in protecting the public. Currently, the National Board is one of 14 health professional National Boards and it's functions are to register nursing and midwifery practitioners, to develop standards, codes and guidelines for the nursing and midwifery profession, to deal with notifications, complaints, investigations and disciplinary hearings, to approve accreditation standards and accredited courses of study for existing and emerging qualified nurses.

The Nursing and Midwifery Board of Australia of Competency Standards for the Registered Nurse (Nursing and Midwifery Board of Australia, 2006) clearly identify the 'what' and the 'how' underpinning goals and intentions for OQNs and ANs to gain appropriate education to qualify for work as Registered Nurses in an Australian health care organisation. As Registered Nurses, they all share a common responsibility to adhere to the regulations and policies of their profession and organisational demands as well as Australian societal mores.

To practise in Australia, OQNs need to satisfy the AHPRA standards for registration. They also need to meet an additional requirement of English proficiency by providing evidence of having satisfied either the International English Language Test System (IELTS) 7.0 or Occupational English Test (OET) level B if their nursing education was not conducted in English. Given that there is universal university based nursing education in Australia, OQNs are also assessed for equivalence of prior education

(sometimes including additional education) to demonstrate equivalence of their preparation for practice. The Board-approved Australian nursing and midwifery qualification is a Bachelor level degree as a minimum and this must align with the Australian Qualification Framework (AQF) level 7.

4.2.3.3 National Competency Standards for the Registered Nurse

Nurses are assessed on their education and practical performance against the National Competency Standards for the Registered Nurse (or Midwife) to obtain and retain their registration in Australia. The nurses in this study were expected to meet four domains of the Competency Standards: Professional practice; Critical thinking and analysis; Provision and coordination of care; and Collaborative and therapeutic practice. Demonstration of practical elements requires nurses to practise in accordance with legislation affecting nursing practice. Essential elements of critical thinking and analysis demand they engage in reflection on and about their practice, to continue professional development and use evidence from research to inform practice. Provision and coordination of care is the nurses' responsibility. Functions include organisation and provision of safe and quality patient care. Collaboration entails development of a professional relationship with others in order to work effectively within an interdisciplinary health care team.

To meet the requirements of these elements of competence within the domains, a number of frameworks and guidelines inform the nurses about protocols. For example, the Scope of Practice for Nurses is designed as a legislative and regulatory framework. It sets down requirements for the range, breadth and depth of elements of practice for different job classifications within nursing. Another example is the National Decision-making Framework that arose from the definition of Scope of Practice and informs the requirements for competencies of all nurses and midwives (knowledge, skills and judgement), professional accountabilities and responsibilities of the clinicians. There is

a requirement for nurses and midwives to use it as the foundation for establishing decisions about care that are consistent with standards of practice, appropriate education, the suitability of roles and responsibilities. The existence of such a framework conveys to the public the characteristics of who is qualified to provide particular nursing services (ICN 2013). Nurses and midwives are expected to know about and adhere to these policies and guidelines in their practice.

4.2.3.4 Professional Conduct and Ethics

Along with being competent clinically, Code of Ethics (ICN, 2012) and the ANMAC's Code of Professional Conduct for Nurses in Australia provide the details on the manner in which a RN is expected to behave while acting in a professional capacity in order to ensure the 'good standing' of the nursing profession. These are frameworks for the guidance of clinicians to be legally and professionally accountable and responsible in their practice. While the provision of care is the primary professional responsibility for clinicians, promoting an environment that respects human rights, values, customs and spiritual beliefs of people forms part of the expectations for therapeutic care. The codes emphasise the professionals' values such as respectfulness, responsiveness, compassion, trustworthiness and integrity. These also set an expectation around behaviour towards co-workers, that is, to have a collaborative and respectful relationship and to support and guide each other to advance the likelihood of the most ethical conduct within the profession. These Codes guide OQNs and ANs to be respectful of differences, collaborate with others, co-ordinate health care and demonstrate lifelong learning to achieve the highest quality and safety in nursing care.

The ICN's Code of Ethics demonstrates the strong commitment of the ICN in guiding the nursing profession internationally. It has served as one of the standards for nurses worldwide since it was first adopted in 1953.It is a guide for nurses in appropriate decision making about their activities, including everyday choices and refusal to

participate in activities that conflict with processes that progress caring and healing. As mentioned earlier, nurses are expected to be competent to work with cultural and linguistic diversity. The Code specially requests that nurses have respect for human rights, including cultural rights, the right to life and choice and to dignity and to be treated with respect, regardless of differences such as age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status. Hence, this code asserts a need for adherence to the maintenance of the culture of safety for all regardless of any differences.

In Australia, the ANMAC Code of Ethics, in line with the ICN's Code of Ethics, continues to focus on values at all levels within the disciplines and areas of the profession framed by many principles and standards such as the *United Nations Universal Declaration of Human Rights, international Covenant of Economic, Social and Cultural Rights and International Covenant on Civil and Political Rights and the WHO Constitution and Health and Human Rights*. Under the Code, nurses are asked to "respect, promote, protect and uphold fundamental rights" of patient and their colleagues. The OQNs and ANs as Registered Nurse are expected to value the provision of quality nursing care, respect for self and others, the diversity of people, participation of informed decision-making, and a culture of safety while working together.

4.2.3.5 Pursuing excellence

All OQNs and ANs are governed by a number of programs and regulations in their work and are encouraged to pursue excellence. For example, the National Safety and Quality Health Service Standards (NSQHS) of the Australian Commission on Safety and Quality in Health Care aim to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that ensures minimum standards of safety and quality; the nurses within their employing

organisations need to be competent to perform their duties to meet the standards. Another example is HNELHD's excellence program. With the banner of *Excellence, Every patient, Every time,* it provides specific tools for communication and engagement. It provides a mechanism for nurses to provide a planned and disciplined approach to doing the right thing for patients and their families, doing it consistently, and doing it with respect. It provides for nurses to make the provision of quality and safe care to patients as their everyday business. This provides a framework to promote ethical day-to-day conduct and decision-making.

4.2.4 Building a positive, safe and healthy work environment

A number of generic documents which guide the nursing and midwifery workforce as a whole discuss building a positive, safe and healthy work environment to enhance OQNs' and ANs' achievement of quality outcomes and safe provision of nursing care. A positive, safe and healthy work environment supports excellence and decency in approaches to work. While they strive to ensure quality and safety in health care to patients, they also acknowledge the importance of the personal wellbeing of staff. Supportive environments improve the motivation, productivity and performance of individuals and organisations. In the following, this is elaborated upon under four subthemes: Workplace health and safety management, respectful workplace, supportive organisations and overseas staff support program.

4.2.4.1 Workplace Health and Safety Management

A number of policies and position statements are in place to protect nurses in their workplace. The *Work Health and Safety Essentials for Nurses and Midwives*: the NSWNMA, in partnership with WorkCover NSW, has produced guidelines on how to protect the safety of the workers. This is the second edition of Occupational Health and Safety (*OHS) Essentials for Nurses*, now called Work, Health and Safety (*WHS)*

Essentials for Nurses and Midwives. These legislations are to manage or eliminate the risks from work performed in daily practice. *Occupational health and safety management program for nurses* (ICN, 2006) also promote the safety of nurses at work. In addition, *Positive Practice Environment for Health Care Professionals (*International Council of Nurses, International Hospital Federation, International Pharmaceutical Federation, World Confederation for Physical Therapy, World Dental Federation, World Medical Association, 2008*)* is about promoting a quality workplace for multidisciplinary health professionals by providing safe, cost effective and healthy workplaces, hence strengthening health care systems and improving patient safety.

4.2.4.2 Respectful workplaces

A number of documents direct nurses' attention to the importance of having a respectful workplace. First, at the global level the ICN's position statement enforces the importance of violence-free, safe workplace for nurses and ANMF's *Bullying in the Workplace* statement approves the sentiment that bullying in the workplace is to be prohibited and equal opportunity is to be promoted in the workplace. The intent of these statements is to guide clinicians in their interactions and behaviours.

Further, a number of other policies and guidelines emanating from the NSW Ministry of Health support the notion that a respectful workplace is conducive to the maintenance of safe and positive working relationships within and across cultures and the provision of optimal patient care. These include:

- NSW Health Core Values
- PD2012_018 NSW Health Code of Conduct
- PD2011_018 Bullying – Prevention and Management of Workplace Bullying in NSW Health
- PD2005_315 Zero Tolerance to Violence in the NSW Health Workplace

- HNELHD Pol 11_03 Respectful Workplace Policy and PCP 1 Policy Compliance Procedure
- HNELHD PD2011_018:PCP 1 Preventing, Reporting and Managing Workplace Discourtesy, Bullying and Harassment
- HNEHD Pol 11_03:PCP2 Counter Workplace Racism
- NSW Health, Health Professionals Workforce Plan2012-2022
- NSW Health The Workforce Culture Framework
- HNELHD Equity and Equality Opportunity Management Plan

Similar to those policies, the Code of Conduct - NSW Health also requests nurses to promote a positive work environment by treating patients and others with courtesy and respect. It asks for consideration with due sensitivity to the needs of people with different backgrounds and cultures. There is to be no tolerance for bullying or harassment or discrimination the basis of their sex, race, ethnic or ethno-religious background, marital status, pregnancy, disability and age. In addition, the NSW Health Values of Collaboration, Openness, Respect and Empowerment among its staff and the Respectful Workplace Policy direct nurses to focus on treating all people with dignity and respect. The commitment of the LHD to develop and maintain respectful workplaces is also demonstrated by the organisation's recruitment of two designated respectful workplace consultants. Professional nursing organisations and health care organisations where OQNs and ANs work promote the notion of the importance of a respectful workplace without the risks to staff members and patients associate with workplace violence such as disrespect for others, harassment and bullying, racism and discrimination.

4.2.4.3 Support for continuous learning and safety

Besides promoting workplace health and safety and respectful workplaces, policies and guidelines of a number of health and professional organisations actively support

nurses. They expect professional behaviour to inform the way they perform their roles and functions properly while at work. The NSW Ministry of Health, along with the Australian Government and other State/Territories Ministries of Health, provides guidance on how to establish and maintain a safe environment for optimal patient and client care. This is evidenced in their vision statement “Healthy People - now and in the future”. A number of dedicated units within the NSW Ministry of Health support the ongoing education and training of nurses and optimal patient care.

The Clinical Excellence Commission (CEC) has a central role in the responsibility for assurance of quality and safety in the NSW health system by promoting and supporting the development of strategies for improvements in clinical care, minimisation and risk and maintenance of safety and quality across NSW. This is driven through training and education initiatives, such as the Clinical Practice Improvement and Patient Safety programs.

Second, the Health Education and Training Institute (HETI) undertake a core role in supporting the NSW Health system in the design and implementation of its education and training requirements. Many courses developed by HETI are closely linked to the national standards for quality and safety and other standards informing specialty health issues and procedures to ensure the provision of qualify and safe care and the assurance of a competent workforce. Some of courses specifically aim to promote a positive, safe and healthy work environment and maintain competent personnel within workplaces by developing the capacity of the teams of staff members; explicit resources such as “Building effective teams”, “Inter-professional communication”, “Team work - team process”, and “Working in culturally diverse contexts”. These learning modules within a range of courses are focused on team working in a functional way with emphasis on the importance of communication in minimising adverse events and respect for cultural diversity that influences expectations about care.

Thirdly, the Nursing and Midwifery Office (NAMO), is directly related to the wellbeing of nurses by providing advice on professional nursing and midwifery issues and on policy issues, monitoring policy implementation, managing statewide nursing and midwifery initiatives, representing the NSW Ministry of Health on various national and state committees, and allocating funding for nursing and midwifery initiatives. Practice Development, for example, is a strategy to develop person-centred cultures, which enables nurses to engage with individuals and teams to blend personal qualities and creative imagination with practice skills and practice wisdom (NSW Health, 2015).

Professional unions such as the ANMF and NSWNMA support all nurses and midwives in Australian and New South Wales workplaces respectively. They represent the industrial interests of all nurses and midwives employed under awards and agreements registered in health care sectors. The belief of the professional unions in the centrality of patients' interests and quality patient care is critical to what nurses do each day, as is reflected in their policies, position statements, and media releases.

At the commencement of this study, there was no evidence that there was a systematic formal program to support OQNs or ANs in the workplace at LHD level. Historically, support for the OQNs was undertaken in an ad hoc manner, and was usually reactive and focused on the "problems" that emerged as opposed to "finding solutions" to the challenges. There was a need to develop a system to take a pivotal role in quality assurance and risk management when a large cohort of OQNs was recruited in 2011-2013.

In summary, as confirmed by the document analysis, there are a number of the expectations and intentions of nurses (both OQNs and AQNs) working in an Australian context. These expectations and intentions are explicit through the provision of guidelines and standards for nurses in order to protect the professional integrity and excellence in nursing practice and a safe work environment in pursuit of optimal patient

care. In the following section, I present two images and an artefact that were provided by the nurse participants to explain their appraisal of experiences of working with each other whether they were the OQNs or the AQNs. As discussed in the methodology chapter, these were intended as a means for the nurses to describe the idiosyncrasies of individual nurses' experiences. The latter are those that most contribute to personal, professional, organisational, and socio-cultural elements within the experiences that were reported in interviews as part of their daily practice. It was also hoped that asking for the images and artefacts would provide greater insight into what the OQNs and the AQNs in their workplaces ''live with'' as they become socialised and acclimatised to working together in an Australian context.

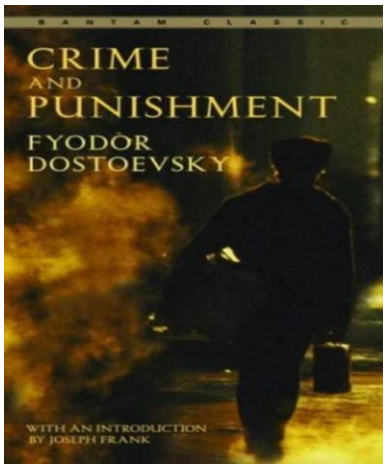
4.3 **INTERPRETATION OF IMAGES**

The initial purpose of using imageries was to minimise the possible impact of the requirement that interviews were to be conducted in the English language given that for some participants English was often not their first language, despite the fact that they had satisfied the English language requirements for registration. Use of imageries assisted these nurses to give greater personal insight into the appearance of an event or a persona as a metaphor of an experience that has been closely associated with the initial idea or relationship associated with cross-cultural experiences.

Three visual narratives allowed these participants to reflect on their experiences, by evoking memories about these and other situations from their personal and working lives. Participants used these memories to construct and reconstruct the experiences as they shared their stories with the researcher who was also part of their professional community, and had experienced both the Australian and an overseas community. Both the imagery and the associated narratives made more visible or overt, the different parts or narratives as well as enabling an opportunity to explore different positions within a dynamic environment or situation. In the following section, the

participants who formally submitted their images described their journey of working in a novel situation where they crossed different cultures and health care environments. Each image was able to explain their journey; either in the beginning, as part of a journey through experiences involving acclimatisation, acculturation or socialisation, and facilitates the processes involved in reflecting on those experiences. Although only three pieces of imagery were provided by two OQNs and one AN during the interviews, the narratives behind those imageries presented the stories of others conveying similar sentiments in similar ways during the interviews.

4.3.1 Jean's story-In the beginning



Jean, an Australian nurse, commenced her nursing career in her 30s. She worked in a tertiary referral hospital at the time of the interview. The image that she presented to explain her experiences of working with OQNs was the image from the cover of a book called 'Crime and Punishment' by Fyodor Dostoevsky, a Russian philosopher.

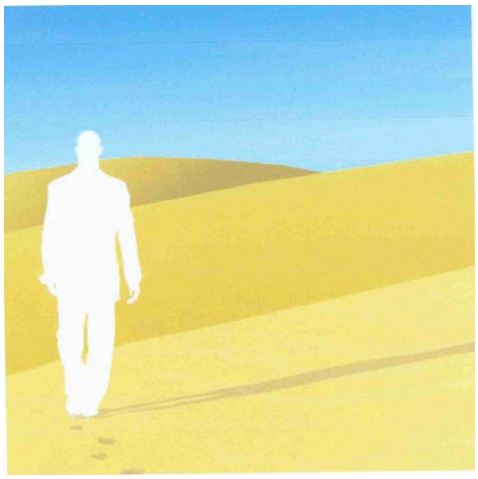
Jean made a couple of points that related to the study. First, she explained that it was not her intention to present her experiences of working with OQNs as 'dark and depressing' but to explain how she found herself becoming 'uncertain of herself' as she saw her working experience with OQNs as a novel situation. She then provided reasons for her loss of confidence as being related to her lack of knowledge about OQNs as people, as nurses and as members of society. She experienced differences

in cultures, the level of their nursing skills, and knowledge and experiences. Working with OQNs was a ‘testing’ situation even if her past experiences working with people from different cultural backgrounds helped her out a bit in other workplace outside nursing. She added that although the nurse education should have been able to at least inform her and hopefully enable her to be competent to work with people from diverse backgrounds. She felt that she had not been prepared to work with co-workers from diverse backgrounds.

Jean believed that culture was embedded in everything and explained how this book showed the enormity of the impact of the presence of something that was alien to her. She sensed that others would experience a similar impact, given that certain elements of the culture were embedded right into all levels of society. Jean narrated how neither the main character, or by-passers raised concerns when they did not understand what was happening even though they realised the situation wasn’t normal. There was no concern shown or help provided to the main character prior to him committing a crime. The people and society let him down.

This reaction was present for her as a snapshot of her experience at this time. As an example, she explored her experiences of having difficulties addressing the OQNs correctly and of her interactions with the OQNs and concluded that this was due to her lack of understanding of the cultures surrounding them. She detailed how ‘socially implied names’ were used among the ANs when they face this naming issue. She also expressed her feeling of unfairness about this practice, but she felt she was limited to act on that on her own, as this was a normal practice at the workplace. This is elaborated upon in the interview data.

4.3.2 Harna's story -The journey 'through'



Harna was a Korean born nurse working in a tertiary hospital. She needed to complete a one-year transition course at an Australian university prior to gaining registration and employment in Australia. Her first job in this country as a RN was as a newly graduated nurse in a tertiary hospital, even though she had a number of years' experience since completing her initial registration in Korea. She had searched to find this image on the internet to explain her experiences working with the ANs. She referred to this image to explain what she meant by her reports of her experiences at the commencement of her interview. Harna explained her experiences of working with the ANs in the Australian context as a journey of being in the "Blank"ness, as traversing through "survival and struggles", and of herself feeling "half full".

"Blank"ness

Like Jean's reports of uncertainty and confusion at the beginning of her working life with people from different countries of origin, Harna articulated her feelings about the beginning of her working life within the Australian nursing practice setting as working in "blank"-ness". She clearly described her early experiences in Australia as 'creating a new beginning' in an effort to build on who she was. The person in the picture presented in the white colour represented the feeling of "no colour" to her and as a sense of being "blank" about her understanding of her nursing career in Australia. This

interpretation represented her sense of losing her persona with her own colour, which she believed would have been filled with green or yellow before her arrival in Australia. Her new life in Australia was about refilling the colour. Harna described the processes of that change in two different ways: personal identity and professional identity change. She described how she felt lost her own self when she entered the Australian nursing practice setting.

Survival and Struggles

Harna expressed how it was a struggle for her to enter an Australian nursing practice setting. Although it was so difficult and so painful that she was in tears while talking about this during the interview, she believed that this transition to another culture was a necessary process, a rite of passage. Harna explained that the transition was a progressive procedure that needed time for her to progress. Harna also explained the reasons why it was struggle for her. One of the reasons was that there was 'no sign post' for her follow. Using the word 'desert' she explained that the journey of working with other nurses in the Australian nursing practice setting was difficult, like walking through a desert without a signpost to say where to go, no shade to have a rest in, and no water hole to get a drink from. No guidance or support was given to her so she was left alone to figure out what to do to survive like standing 'in the middle of the desert'.

While she recognised that nursing practice was about working with other people and patients, like the sand on the desert that she had to walk through, the pathway that would enable her to find and understand others was her own journey. Other reasons she provided for her struggle were her loneliness, withdrawal, and experience of bullying and racial discrimination at work in Australia. She continued to say that she felt powerless and experienced a sense of hopelessness. She was embarrassed and she tried to hide that embarrassment with empty laughs during the interviews. Harna articulated differences as reasons for her many struggles in the Australian nursing

practice setting. Like Jean, she was not well prepared to work with other nurses from different cultures. She recognised many differences in culture, in nursing practice and in use of language, cultural norms in communication and interactions.

Harna emphasised the need for support from the nurses and the system, equality in opportunities, being respectful and acceptance of OQNs, being included, and the creation of a sense of helping one another among nurses. She also explained how she was self-motivated to improve her communication skills in Australian ways and to learn Australian nursing knowledge and skills.

To half full

Although the journey was depicted as a survival of the struggles that she needed to overcome, Harna professed that it was a worthwhile journey for her to come to Australia and work in an Australian nursing practice setting. Harna said she would be in the same position as any other OQN who came to Australia. She was now in a comfortable state, thriving as a nurse who could help others. She recounted this as due to acculturation, acclimatisation and socialisation; not limited to the transition into the Australian nursing practice setting, but also to her growth as a person. Now, she was able to recolour the blank space of the figure in the image as green, giving the reason for the green colour as her wish to being liked by others, but especially by other nurses. This provides evidence that she was still looking to being accepted after more than ten years in the Australian nursing practice context.

4.3.3 Bao's story- Reflecting

Bao was a Chinese nurse born in Hong Kong, who immigrated to Australia following her husband, a second-generation Chinese medical officer. While she was trained in a hospital-based course, the course was in English in Hong Kong, so she was not required to complete a transition course to obtain Australian nurse registration. Instead, she attended a bridging course that assessed her clinical competency against Australian nursing standards.

Through the choice of this image, Bao was trying to describe her experience of working in the Australian nursing practice setting as both 'turbulent' and 'amazing'. She said that the picture represented those years working in Australia as like 'sailing a yacht in the sea, (it is) sometimes calm, sometimes within a storm'. Similar to Jean and Harna, Bao's experiences in the Australian nursing practice setting were suggestive of the challenges she faced and the sense of fulfilment she had. She identified a number of challenges such as difficulties in communication, different social norms and interactions influenced by the egalitarian approach and the hierarchical culture, and disrespectful behaviours from ANs.

While she faced a number of challenges, she was also satisfied with her decision to come Australia and to work. She enjoyed her family and her lifestyle in Australia. She

praised the egalitarian culture in both the wider Australian society and at work. She completed the interview saying that in the "ideal world or situation, everyone not only contributes 100%, shares the common goal which is to 'provide quality care', between 'understanding' people, colleagues. Understanding is very important."

In summary, the narratives behind these images depicted how each nurse interpreted their journey and experiences of working together within the Australian context. The following key points were identified from the narratives of the images:

- Working together for the OQNs and ANs is generally a novel situation.
- The journey and experiences are not static, but changing continuously with time and space (in the Australian context).
- A nurse's journey of working with nurses from other cultures is like drawing a new picture on a blank canvas; there is a need to lose the past "me" and make a new "me" both as a person and as a professional.
- The journey route is paved with many struggles and experiences of satisfaction.
- The success of the journey is dependent on the nurse herself/himself as well as on others.
- A number of differences can be identified while some commonalities are shared among them.
- There is evidence of professional dissonance in their behaviours, conduct and experiences in interacting with the other.
- Cultural difference and expressions of 'the other having greater influence or power over you' are super-ordinate features overarching the personal, organisational and societal differences and professional dissonance.

4.4 **CONCLUSION**

Review of documents in this chapter has identified key concepts, which are intended to inform nurses about expectations of professional conduct and the creation of a sense of efficacy in the workplace. However, in discussions about the images formally presented by some participants with the researcher in this study, the narratives conveyed greater depth in expressions of outcomes. There was a sense of dissonance, difference, a need for better directions on acculturation and greater sensitivity on more appropriate use of the power. Although, only three people offered images to explain their experiences, other interviewees' contributions resonate with the sentiments reflected in these images. Interview findings are presented in Chapter Five. Personal reflections on the extent to which the documents reported on in this chapter were fully appreciated by the interviewees are also provided in Chapter Five.

Chapter 5 CHAPTER FIVE: THE EXPERIENCES

5.1 INTRODUCTION

In the previous chapter, I examined documents that impact on how OQN and ANs at work and the images that were provided by participants to explain their experiences of working with each other. In this chapter, I present the findings from interviews conducted with 13 nurses: eight OQNs whose initial qualification was obtained overseas but who have satisfied requirements to register and work in Australia as an RN and five ANs. Together, their experiences provide understanding of the disparate and shared nature of what it is like to work together as nurses in an Australian health care context. There was some variation in relation to how long OQNs had been practicing in Australia. Hence, their stories are not solely about transition but rather include a broader and ongoing process of engagement.

In line with the methodological framework presented in Chapter Three, the findings are presented in four dimensions of experience: as personal, professional, organisational and socio-cultural; the latter is relevant to the wider community and Australian culture. At the end of each section, the researcher provides details on her personal reflections from her memos. Figure 4 illustrates these dimensions of context and experiences contributing to a better understanding of how the nurses from diverse backgrounds work together. In some instances, the themes arising from analysis of the transcripts were equally pertinent to more than one dimension. The choice about where the findings were discussed was made after consideration of the alignment with the expectations outlined in documentation provided in the previous chapter Four.

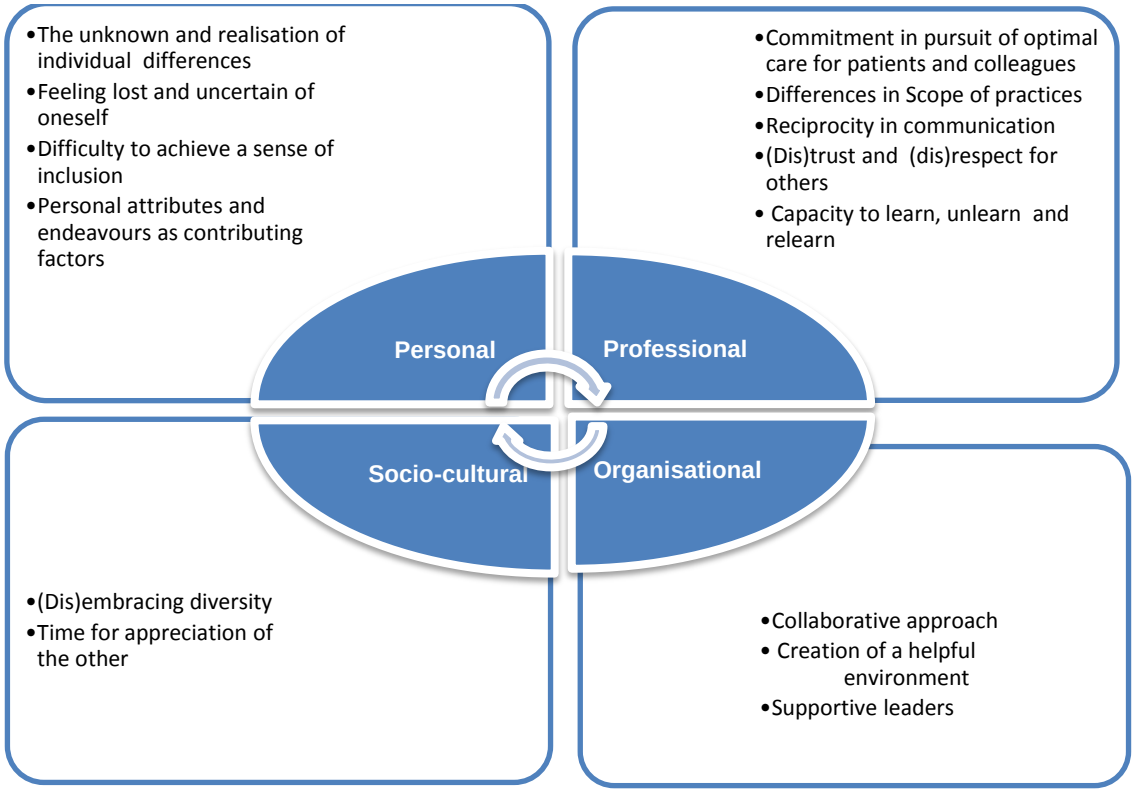


Figure 4: The superordinate dimensions of Context and Experiences

5.2 PERSONAL EXPERIENCES

Personal experiences included those that relate to individuals and the differences among them, including ethnic diversity. This dimension is presented under sub-themes - *the unknown and realisation of individual differences, feeling lost and uncertain, struggling to achieve a sense of inclusion, and personal attributes and endeavours as contributing factors*. All participants were Australian RNs who were working within an Australian health care setting. Working with nurses who obtained their initial qualification from different countries of origin was a novel situation and a new experience for both OQNs and ANs. As discussed in chapter three, the group of nurses who participated in the study were characterised by diversity in relation to language, skin colour, past work experiences and education, and length of stay in Australia.

Perceptions about these individual differences varied among the nurses. Some, like Bonny, viewed workplace diversity positively and as part of a normal phenomenon resulting from globalisation.

> *It's good to have a wide range of people with all sorts of different experiences and backgrounds…it reflects what our population is anyway and it's good for ourselves to be exposed to things that are not what we're used to.*

Bonny: AN

5.2.1 The unknown and realisation of individual differences

In spite of a shared sense that diversity in the workforce is a good thing, many participants described working together in the context of diversity as encountering a lot of 'unknowns' and they came to a realisation of how their individual differences impacted on them working together. Both the OQNs and ANs identified 'unknowns' as an issue for them and indicated it impacted their ability to interact and perform confidently, even if there was the positive intention to work together in a respectful and inclusive way. The nurses discussed the unknowns from different aspects of their 'being' as a person and as a member of a socio-cultural group and as professionals. The concern was 'not knowing' about others and what to expect from them.

> *I don't know much of her culture. I don't know enough about her.*

Kim: AN

> *I didn't really know what to expect from Australians because I hadn't met many Australians prior to coming to Australia.*

Dean: EnN

This sense of the unknown was a particular concern for the OQNs from Non-English speaking backgrounds, even though they had undertaken transition programs that

were supposed to prepare them to work as nurses in Australia. For example, Harna explained how uncertainty about something as simple as the way in which to greet people created confusion, as depicted in the following excerpt:

> *Like how you say good morning* [here]*, when we bow our head instead of saying good morning, they don't know what I am doing* [Laugh]. *But it was a natural thing for me.* [However] *they don't understand what I'm doing. And they just laugh at me.*
>
> Harna: KN

In a similar way that Harna explained confusion over ways of greeting people, addressing others by name was also problematic for Australian nurses. For example, Jean described the difficulty she had with the names of OQNs.

> *The greatest problem* [is] *their names. On the roster,* [it] *does not necessarily show how you pronounce the name and the first thing you've got to do is* [to] *find out how to pronounce their name or what it is they wish you to call them. What's on the roster book may not be what they are called. ..//.. they're sick and tired of people that can't pronounce their names. They have Australian nicknames.*
>
> Jean: AN

Harna also emphasised the importance of cultural understanding, the weight that Australians place on certain aspects of their culture, the notion of habitus (what comes naturally from cultural conditioning) and that people in Australian know very little about her own Korean culture

> *I don't know their culture. I don't know their history much. I did not know cricket. I never watched the cricket in my life until I saw it on TV ten years ago in*

Australia. Australian people don't know about our culture.

Harna: KN

Kate highlighted the fundamental differences that are evident amongst her work colleagues and how these differences impact on life beliefs and values and the way in which various situations are interpreted on the basis of cultural norms and expectations. However, she also highlighted that they were all nurses in common in spite of their individual differences.

> *We are different…different backgrounds ..//..There are language differences. You look different; you eat different food ..//.. values are different ..//.. different attitudes. I think sometimes a lot of foreign trained people would sort of take offense or they'd look at it as though somebody was having a go at them, whereas we do that as our communication (style). How we interpret, how we understand that sort of thing. I think the* [Nursing] *training is basically reasonably the same isn't it?*
>
> Kate: AN

Given Australia is one of the most multicultural countries in the world, diversity among the nursing workforce would be assumed as a common feature, and should be affirmed and accepted as identified in the document analysis in the previous chapter. However, individual difference affected the nurses and their ability to work together harmoniously and there were some nurses who clearly did not aspire to be competent in dealing with this diversity. This led newcomers to feel lost and locals to express a sense of uncertainty and to question the clinical competence of OQNs. Not knowing about each other, combined with particular inherent and individual differences led some to feel confused and intimidated, and then to stereotype, offend and blame others. Joyce, an American nurse explained how ANs stereotyped Americans and how she felt that, she

was being treated as an outsider even though she had been in Australia for more than 5 years and was an Australian citizen.

> [They think] *we all eat at McDonalds right, we all watch the Simpsons ..//.. their stereotypes of Americans, we're a bit obnoxious and have an opinion about everything ..//.. it's really frustrating… they assume that I represent all Americans. ..//.. And so, I get bagged on [sic] for electing George Bush again and that sort of stuff. ..//.. that's a bit annoying and I don't think that ever stops because you'll always be deemed as an outsider - 'cause you still have an accent, your family's still back home so when you talk about home, it's there.*
>
> Joyce: AmN

Kim, an AN, recalled a socially and culturally provoked action where an Egyptian nurse was offended, referring to it as one of 'these 'little things', whereas, an Egyptian nurse indicated that the same incident was the 'highest insult'. Kim had not understood the significance of an action such as showing the sole of the foot, she said.

> *Little things that really offended her like if someone in the tearoom showed the sole of their foot, she would be highly offended but we didn't know that for years..., she would just get up and walk out and go back to work. It took years before she said, "It's an insult, the highest insult to show a woman the bottom of your foot.*
>
> Kim: AN

Kim, described her personal experience of not knowing that practices taken for granted and as the 'routine' for ANs may be unknown and foreign to OQNs. Further, she explained how she changed to accommodate the differences in practice.

We had one [OQN] *who didn't realise she was entitled to breaks or didn't want to take a break because she wanted to show she was a hard worker. She would sit at the desk and put her head down on her hands like this and close her eyes* [laughter]. *I talked to her and I said you can go and have a break, you know you are entitled to have morning tea and lunch; 'She said working in the Philippines you didn't have a break you just put your head down and had a little nap, a cat nap… When someone new comes, just spending time sorting out those simple little things.*

Kim: AN

Jean described how some ANs developed a practice of using a 'socially implied name' for OQNs and how she felt that practice was unfair, even violating the rights of a person and her inability to stand up to this.

It was the cultural acceptance in this ward that we will call them what we want to call them because that's all that we can pronounce ..//.. This person [OQN] *told me what their name was ..//.. other nurses* [ANs] *said no we just call her such and such… I thought well that's like a socially implied nickname on this person. It wasn't her name and you sort of do it in sort of a joking way, if you are going to call her that can I call you chook? And they'll be like 'no' because I'm not a chicken … why are you calling her that because that's not her name you know. So you can agitate a little bit. Generally it's only one or two people in the ward that will insist on it.*

Jean: AN

The 'unknowns' led both OQNs and ANs to be challenged within their workplace, with ANs often questioning the ability of OQNs rather than attempting to understand their prior experience. At the personal level, nurses wished to 'know each other' at the outset. Kim said that "once you get to know the person ..//.. You are more comfortable

..//.. and work better". Bonny an AN, while empathetic about OQNs' feeling that coming to Australia was an 'alien' experience, agreed that getting to 'know the other' meant it could have been easier to work with OQNs.

> *I think that's important to know where they're coming from. Because, we have an expectation of what work has to be done, what jobs are required and ..//.. in overseas countries ..//.. some of the parts of work that we do as nurses in Australia are never done by RNs in other countries. There are always things to consider with OQNs - what their cultural experiences are, what the expectations have been where they've worked before and what our expectations are of them.*
>
> Bonny: AN

Jean added that nurses should know how to deal with differences and that 'unknowns' should be expected and anticipated. She provided an example from her experience of a new graduate nurses' rotation program in which she faced new work environments and new staff with each every rotation.

> *Generally, I've got like a standard way. ..//.. because I change wards a lot, I'm very adaptable and so I always make a point of saying hello to everyone on the ward anyway as a person that I'm working with, so if I didn't know this person and I went up to them I'd still tell them 'hi I'm J and I'm a second year* [nurse]. *I just introduce myself to people and I say what's your name. ..//.. take it from there and once you get to know people better then you work around their personalities and the way they joke and some of the things you learn so It's the same with everyone really.*
>
> Jean: AN

The reports on the personal experience of the nurses suggested that their working together was a novel situation, causing them to deal with the 'unknowns' and many individual differences. In contrast, the various formal documents indicated expectations that the nurses accept difference and demonstrate competence to deal with this diversity. This experience of confronting unknowns and differences at the outset led them to feel unsure of their actions and beliefs and affected their attitudes towards each other. They often felt lost in the processes of acculturation and acclimatisation when encountering others who are different from themselves in an environment where the onus is on them to work effectively together.

5.2.2 Feeling lost and uncertain

Being uncertain meant that participants had no clear direction in how to respond in certain situations. This was evident when Joyce said, "I had no idea what they were talking about". However, the personal differences she identified, resulted in her feeling intimidated, experiencing a loss of confidence, and a sense of annoyance when she failed to appreciate what she called "stupid little things".

> *I was a bit intimidated by that because even though it's still English, the drug names are all different. They call things different. ..//.. somebody was asking me for an IV bung. What's an IV bung? I had no idea what they were talking about. I thought it was a difference size IV, cannula - I had no idea. And it's just the cap on the end of the cannula. It's stupid little things like that makes a big difference because it can sort of make or break your day.*
>
> Joyce: AmN

The other nurses all expressed an apparent discomfort with facing perceived differences and expressed different degrees of discomfort Harna highlighted how extremely chaotic and difficult it was for her; she felt she was not prepared to work in Australia even though she had completed a year-long transition program.

I needed to start again at the beginning. You sort of start with really chaos..//.. And it wasn't that easy. ..//.. [It is like you are] *in a desert there's no directions. And you have to survive yourself. It's* [personal canvas] *so white, blank…you have to make it (work). It was really stressful. Getting up early in the morning, you'd think, how can I just … survive today, you know it's just really hard, it was hard.*

Harna:KN

This loss of confidence was shared by ANs, working with OQNs in some situations made them feel uncertain about themselves. Jean, an AN, described how she felt inadequate working with nurses from other cultures by referring to a character from the novel 'Crime and Punishment'. Being in a new context unsettled the nurses even though they might see themselves as experienced and professionally competent

The character [foreigner] *sees himself as completely logical, rational… he is in his own sense, but when he meets people who can't understand what he's saying… I don't know…how they relate to him…is completely different* [to him].

Jean: AN

Joyce also described her experiences of facing different contexts of practice as 'humbling' and how she felt a loss of confidence even though she had more than 5 years' experience in America.

What I found most difficult is coming from ICU where I've had years of experience where I was quite confident and I knew what I was doing in my job and then coming into a completely new environment and not knowing anything and really being dependent on everyone like where do I find this? What do I do with this? What does this mean? What's this surgery? It's really quite

humbling, just being so confident and maybe it is a bit of autonomy as well.

Joyce: AN

Like Harna, Joyce and Jean, Bao from China expressed how encountering different nursing practice from that of her country of origin made her feel like ‘a stranger’ in Australia and also in relation to her nursing practice. She was conscious of others’ opinions and internalised the differences, portraying herself as being strange, saying, “I looked at them a bit hesitant and then they think ‘what are you thinking?” This feeling of being lost and being in a struggle was also depicted in other nurses’ experiences evidenced by the provision of their images portraying “no sign post to follow” and terms such as “sink or swim” used by Harna (KN), Dean (EnN) and Bonny (AN). OQNs and ANs did not know how to get assistance with their sense of helplessness arising from lack of knowledge about what is the right thing on what to do in a given circumstance. This was in spite of clear instruction from a number of professional codes and documents on how to work with each other within a diverse workforce were being available to them.

I don’t know what assistance (is needed) - whether there is actually a system of support or not.

Bonny: AN

As evidenced in these reports, nurses’ personal experiences showed a sense of feeling lost and uncertainty of oneself as confidence about how to behave diminished. Questions arose about how to relate to and deal with unknown characteristics of others and differences. Personal experiences portrayed difficulties in achieving a sense of inclusion and connectedness.

5.2.3 Struggling to achieve a sense of inclusion

Inclusive behaviour is an essential element for a multicultural workforce and more broadly within society but this also requires a personal commitment as outlined in the organisational and professional documents that are providing direction to individuals. In particular, the "*People of Australia and Multicultural NSW Legislation Amendment Bill 2014*" demands the commitment to a just, inclusive and socially cohesive way of behaving in in our daily lives. In the interviews, the nurses discussed a number of opinions on inclusion or exclusion drawn from their personal experiences. They talked about developing relationships with others and the difficulties in developing inclusive personal relationships.

Participants suggested English language ability was an important factor for one to feel a sense of inclusion. Michi explained how she was not confident associating with others because of her perceived inadequacies in using English and in understanding different topics. She explained she had difficulty connecting with other nurses as she experienced difficulty joining conversations with ANs given their cultural practices of personal information sharing and her lack of knowledge of particular issues and the circumstance of others.

> *I am isolated. ..//.. I don't think that they are isolating me. But I isolate myself from them because of language. How can I put it? …making excuses for myself. My language is a bit poor compared to them, that's why I feel so isolated... I don't know if it is 100%* [due to my English ability]. *I cannot catch up with the gossip. And because they gossip, sometimes I cannot get into the conversations. In the (nursing) study area, yes that's fine, I can say my opinions. But when Australian people are talking to each other, someone has to join (you) in (to the conversation) to be included. That's their culture.* [I have

to be] *aggressive* [to be] *included into their conversations*.

Michi: JN

ANs, like Kate and Jean, explained that nurses with limited English speaking skills were excluded in conversations, and from a group. However, the nurses also reported several instances that related to exclusion and inclusion. For example, while Bao found that it was easier to develop relationships when the group was more diverse, as was the case for her when she worked with more diverse groups in Melbourne, she also felt rejected when attempts to build friendships were not reciprocated in her current workplace.

> *One of the nurses, an Aussie, I know she's pregnant. I and an OQN invited her to morning tea; I gave her a baby gift. After that she didn't really call me* [to ask] *'would you like to come to see my baby' you know, friendship is two way. If you take, invite me once, I invited you…but nothing happened.*
>
> Bao: CN

The perception of being excluded or disconnected was also evident in Harna's visual expression of being alone in a "desert". Joyce expressed a similar sentiment, using a metaphor of "No-man's land". This represented her feelings of disconnection from the Australia nursing culture and country and consequent uncertain future. She felt she did not belong anywhere.

> *I don't think that ever stops because you'll always be deemed as an outsider –* [I] *just feel like we're in some sort of no-man's land.*
>
> Joyce: AmN

Similar to these experiences, developing a relationship was not easy at work. This was frequently mentioned as unsatisfactory for OQNs and some ANs. While an informal outing was frequently utilised to enhance a relationship among nurses, nurses (Kate,

Kim, Harna, Michi, Joyce, Jean and Nora) raised concerns that informal social outings such as dinners were not satisfactorily used for socialisation and acclimatisation to promote inclusion of nurses. Rather they were used as a way to exclude certain groups such as OQNs or recently graduated nurses. Jean provided an example of this practice and how this exclusion from events intensified OQNs' sense of disconnectedness when those nurses who attended the event talked about it at lunchtime the next day.

> *Isolation is more like you are part of the ward but you are sort of separate and distinct from the ward. ..//.. So it's like in some ways you are isolated from the social events. They either just won't bother asking you because they want you to work that shift so everyone can go out for tea. I know one or two international nurses in particular; they are just not invited. They're isolated from social outings. And then you're sitting in the tea-room (after the event) and they all talk about how they all went out last week or whatever. So they're sort of just sitting there. They'll be quite open about it like 'I will look at the roster oh look such and such is working and such and such* [are not working] *on that night. We will all go then'. They'll do it right in front of you. I've had two wards do that to me. From the wards point of view, they're sort of outsiders. You don't really have much say in anything that goes on* [in the ward]. *And if you are the international nurse, no one really talks to you except to tell you what to do*.
>
> Jean: AN

Nora noted that even if OQNs were included in the social outings, the connection they made with each other by this socialisation outside work did not always transfer to work environments,

> *After work sometimes you get time to meet out of work and have drinks. it's quite good so you get to see the other side of that person. And some of them,*

sometimes you realise it's antisocial. Maybe socially they are aloof and when they come to work it's the only time they meet people and they don't know how to handle the tension and stuff. Actually the relationship like when you go out for drinks we have fun, we leave work out of it then when we come to work we leave the drinks out of it and it's totally different, more serious and yet I think we just need to loosen up a bit, but still do our jobs you know.

Nora: ZN

It was indeed difficult to be included according to Kate. Kate explained a workplace culture that the inclusion or exclusion of membership in a group was decided by those who were in the group.

The other thing that probably tends to happen is 'little cliques'. Everywhere you work there's always a little 'in group' or a clique. People who work together socialise as well. So often their conversations are about private things. The workplace I think does exclude other people if they aren't part of the clique. So I suppose regardless of whether they're from a non-English speaking background or not. If they were someone who wasn't in that clique they'd be excluded anyway.

Kate: AN

With such socio-cultural influences on the group membership, OQNs discussed how they developed their own groups. Both Bao and Michi described how they felt comfortable and understood by other OQNs even those new to the ward; they felt that they shared situations and cultures.

The Irish and Asian nurses, when we get together we're just having a little gossip. ..//.. But I don't go out with Australian nurses . Sometimes we do have a ward night out. I usually don't go, I feel uncomfortable. I don't get into the conversation with the gossip sometimes. But somehow I feel more

comfortable [to talk to Asian nurses]. *Some actually trained here but they're Asian, (then) I feel more comfortable with them*.

Michi: JN

Other OQNs actively sought ways to build an inclusive relationship with ANs by sharing stories and respecting others. Harna suggested that it took some time to be included.

When I started to work here, I started to open up my life, and tried to involve them in conversation while we're having morning tea or while just working or while you are making beds together. We have a lot of chances to develop a good relationship with work colleagues. Generally I try to respect everyone. And that was my work ethic, my tactic to improve the relationship with others, Australian people. [I believed that] *if you want to be respected you have to respect people.*

Harna : KN

From the examples provided, the personal relationships that OQNs and ANs developed were not seen as inclusive in nature, but rather exclusive and different from that desired by nurses. These were not only influenced by personal attributes, but by the culture of Australia and values of individual nurses.

Nurses pointed out a number of enabling and limiting factors that influenced inclusion in work experiences. Nurses stated that gaining cultural knowledge was necessary for ANs and OQNs to build relationships. Dean from England added that the same gender and sharing a similar sense of humour could make a difference in being accepted or building working relationships. However, the culture of tight social ties within the ANs' community prevented him joining a group, as he was an outsider. He elaborated upon how difficult it was to build a sense of inclusion given difficulties in sharing social spheres even though he was in his current workplace more than 18 months.

Because I'm a male and the other two or three male nurses were very happy to see another guy coming in and I just got on with everyone. It's gone really well I think sense of humour. Australian's have got a pretty similar sense of humour to English, pretty dry, a lot of self-deprecation… they know when they put themselves down and I can relate to that… They've had a lot come through so they know what to expect from us. ..//.. We don't really get a lot of time to see each other. We don't know many people. It's a little bit difficult to meet people here, especially if you are a couple with no children and you're from overseas. ..//.. Newcastle is kind of a very small town. ..//.. everyone knows each other, they all went to school with each other and they've all had kids together and this sort of thing so it's quite difficult to break into groups.

Dean: EnN

In addition, Harna explained how working with others is an important part of being a nurse. She believes that it is important to be friendly and share personal information and experiences in order to be part of a team and get the support you need in order to enhance the connectedness, and to be seen as a good nurse.

If you are a quiet person, reticent person, not talking too much, you can't show your feelings how you feel while you work. Nobody knows how you feel. Nobody knows whether you need support or not and how you are going, about personal life is, whether she loves to work here, no idea. That resulted in her being less connected with a person. And some people are not comfortable with working with her. Working as a nurse, you need to love to work with others. That means you need to share parts of your life. You can be a really excellent nurse then.

Harna: KN

Similar to Harna, Bonny also explained that willingness to accept OQNs as they were as human beings in general was important in the development of connectedness in the nursing practice.

> *Generally getting on with people and that's a big thing in nursing when you're dealing with patients. How you get on with them, understanding they're coming from a different place to you and that their experience is just as valid as yours is and you have to treat them that way. And that also translates to having OQNs or somebody coming from elsewhere or outside of your range of experience, can contribute hugely to your understanding of how humans work in general*.
>
> Bonny: AN

Leah added that the role of leaders and support the new to ensure inclusive practices at work. She explained the role of supporting new staff regardless of background had improved with time.

> *The senior staff here try to encourage younger people. ..//.. try to involve them socially here. ..//.. That makes everyone feel more part of the team… It doesn't matter whether you are an AN or an overseas nurse, it was just to get people to like it here and to be included. The NUM always speak to them (nurses) in their first and second years: 'How are you going, where do you need help?' We mentor and buddy people up. I think there's a lot more support out there for new people than what there ever used to be*.
>
> Leah: AN

For many nurses, it was difficult to achieve a sense of inclusion even if the experience of the nurses showed that both OQNs and ANs aspired to be inclusive in their personal and work relationship.

5.2.4 Personal attributes and endeavours as contributing factors

The nurses in this study felt that working together among nurses from different cultural backgrounds was complex and they were largely left to their own resources and resilience to deal with the situation. Personal attributes expressed as helpful behaviours, being interested in others and accepting, were attributes valued by the nurses. OQNs explained an inclination towards helpfulness and acceptance by ANs was critical for OQNs to adjust to Australian workforces.

> *ANs need to be more accepting and I hope they understand our backgrounds. Some people say you guys came to Australia to be nurses; you have to be perfect from the beginning. But it can't happen from the beginning at all. We need support from our work colleagues otherwise we can't survive. If they keep bullying us we can't survive here. Luckily, the workplace I work, they're really helpful. They really try to understand who I am. So that makes a difference for me. It didn't take long, probably six months. We work as a whole team.*
>
> Harna: KN

Nurses believed that interest from other nurses supported them in many ways. For example, Michi noted how 'little things' like co-worker's recognising people's special occasions was a support to her. It was inferred here, that support in work was similar to support for outside events whether directly related to work or not. It is about continuity of a relationship.

> *There was a basic way. If they have got good things happening like having their son or daughter having a wedding, just give them a card, little notes and give them a little hug and you know that kind of thing, little things make a*

difference.

Michi: JN

Harna, along with other OQNs also explained that the importance of supporting nurses to feel comfortable rather than intimidated in general. Joyce further highlighted collegial support for others describing it as “comradeship” that supported development of social friendships, hence also developing work/friendship relationships. OQNs identified support from other OQNs was also counted as valuable. Nora emphasised the importance of support from each other and the shared experiences of unlearning their own nursing practice and relearning the Australian way.

> *We used to have sessions where we would sit down and share ‘like experiences’ and knowledge of all the nurses from Fiji, Philippines, Australia and England. We all got together once in two months. We’d say* [to] *educators that we used to do it this, we used to do it this way or that way…and at the end the nurse educators would say OK we can’t do this.., we can do this, we can improve this way… we can adopt the British style, we can adopt the Philippine style for these.*
>
> Nora: ZN

Besides support or helpfulness from others, the OQNs also indicated a number of personal attributes that helped individual nurses. Harna suggested, in her case, an optimistic personality helped adjust to new environments and situations. She added that pessimistic attitudes could lead to delayed adjustment to the new situation and might lead to disappointment or even giving up.

> *…a person who is positive, optimistic, and encouraging people: You also need to have warmth and laugh inside of you so you can just be ready to spread this to others. If you are pessimistic or just a timid person, it takes time… it really makes your job harder. You get disappointed with yourself and at the*

end of the work you think, I'm just tired [and] *I'll probably give up my job. If you have optimistic attitudes about everything, it's easier to overcome all kind of problems.*

Harna: KN

Another OQN Suji suggested a number of personal attributes that can help adjustment to working well with others in the reality of the work environment.

I'm pretty good organising my work and I'm really a good team leader and good team player as well. When I started I tried to co-operate with everyone. Initially they think somethings different about you. But [when] *they see your initiative and helping attitude… I think people then accept you. You can't think that everyone should be 100 percent positive toward you anywhere in the world. You should take it all.* [That's] *probably the one reason I get a co-operative environment everywhere. It varies from person to person. I can fit in anywhere* [but] *everyone will not be like me. So everyone can't adjust to everyone else. You can't get 100 per cent compatibility with everyone, but if 80% of the staff are helpful that's very good*.

Suji: IN

Harna and Michi equally emphasised how a willingness to change to develop better interpersonal relationships and understanding of each other helped them to adjust to the Australian health care system and working with other nurses. For Harna, she even tried to change who she was to fit into the Australian ways of interacting each other.

I used to be a really quiet person and a really independent person. When I started to work in Australia, I thought to myself that's not going to help me out to be a good nurse in Australia ..//.. I can be really thorough with the nursing practice but if I don't talk to my work colleagues they're not going to know who I am. Sometimes you need to change your personality. I'm not talking about

changing totally but you just need to develop interpersonal relationship skills. You can be still quiet person but you need to sometimes share feelings and you need to show sympathy to your work colleagues sometimes. As a nurse, that's very important to try to be a pro-active nurse in Australia. Try to be outgoing.

Harna: KN

While Harna suggested a better way to equip an OQN to be socialised into Australian nursing practices, she strongly believed that a personal interest in others and to change was a "must" for all. Michi also agreed with Harna with making changes was her responsibility with realisation that she could not insist that ANs change to adapt diversity at work.

[Whether] *an overseas* [nurse] *or not,* [the person] *have to do something to change. And even if I were born in Australia, speaking English very well, I have to do something for myself to change. I'm not going to ask ANs to change. ..//.. I know overseas trained people. ..//.. could not accept Australian ways of doing things...we need sort of teach them about the facility to train them to work within their scope of practice and that in Australia we work together.*

Michi: JN

Part of changing was improving English proficiency. All OQNs from NESB reported that a greater self-confidence when there was a perception of having improved their spoken English. Harna provided an example of how she felt confident and pleased when she was being acknowledged as being an Australian.

How do they [Australians] *talk? Hi mate* [laughter]. *When I started to learn Australian English it was hard because we* [Koreans] *always have been taught American English. Because I couldn't get rid of that American accent, I'm sort*

of trying to imitate their [Australians] *pronunciations, the way they talk. ..//.. Some patients ask 'were you born in Australia?' I hear that kind of comment, it's a real compliment for me* [laughter]

Harna: KN

This tolerance toward the OQNs' English ability by ANs was important for the OQNs. It seemed that English language issues occurred when they did not have agreement on a given set of meanings or a definition of situations when communicating between OQNs and ANs. They reported that English skills became a problem only when ANs thought it a problem. While OQNs tried hard to build confidence and to improve their English language, there was a need for ANs to be open, to understand and to correct OQNs' English in a respectful, non-demeaning manner.

As reported, the nurses identified a number of personal attributes that improved their personal sense of confidence when faced with the unknown and individual differences. These attributes were derived from the views, values and experiences of individuals that personally held and their embodied ways of knowing and being in the world. However, these personal attributes were also intertwined with social-cultural elements underpinning aspirations for a multicultural Australia, professional and organisational expectations outlined for example within the Code of Professional Conduct and Code of Ethics, Nursing competencies, and HNE Health's core values such as commitment to others, being mindful of their need for a sense of personal empowerment.

To summarise the nurses' personal experiences, it was clear that the personal experiences of the nurses were characterised by lack of knowledge of the other and realisation of differences. While they emphasised the need for acceptance of differences, developing connectedness and inclusive practice and support for the other nurses through helpfulness and being interested in others, there was some evidence that there was a lack of attempts to be culturally and linguistically competent to deal

with differences and even help others. As seen in the examples of individual nurses in discussion about how to improve their personal experiences, largely, the OQNs were the ones who needed to act or change to influence experiences in general even though the not-so positive behaviours were experienced by both OQNs and ANs. The nurses failed to adhere to suggestions about behaviours, regulations, policies and guidelines, by exhibiting lack of competence to deal with situations effectively, exclusionary practice and creating a sense of disconnectedness. This impacted on levels of achievement of acclimatisation and socialisation and to an extent, their personal and professional working relationships.

Reflection: Personal experiences

In my memos about the personal experiences of the nurses, at the outset, I was overwhelmed by reports of nurses' experiences of difficulty and challenge; I was particularly moved given their discussions around images that portrayed their overview of their journey. I realised that both groups of nurses perceived themselves being thrown together to work in a novel situation that they were not sure about. As I listened to the interviewees, I was caused to think about my personal experience of a country different from that in which I undertook my initial education for practice and my own sense of discomfort.

While some of the nurses were sure of what they wanted to talk about, others were initially unsure of what to divulge about personal experiences as they found sharing these was difficult and sometimes caused them discomfort and distress. One interviewee postponed the scheduled meeting - her reluctance centred on her language proficiency. Not only did she not have to worry about her English ability but also I realised she did not want to discuss her experiences of being bullied. Her Korean culture precluded her from discussing bad experiences. However, she decided to

attend the scheduled interview so she could help other OQNs. Japanese and Chinese interviewees expressed the same sentiments. On the other hand, the Australians also wanted to help the OQNs by participating in interviews. They very much focussed on the deficits of the OQNs but at the same time were looking for assistance with solutions. However, they were not able to verbalise personal need for support.

5.3 **PROFESSIONAL EXPERIENCES**

The dimension professional experiences explores the notion of 'being a nurse', in particular in Australia. These discussions include accounts provided by the nurses that related to their professional roles and responsibilities, scope of practice, and nursing competence including the attributes of the nurse such as ethical dimensions of behaviour, their moral obligations and professional attitudes. In addition, their trust in their own professional ability and their responses to the quest for safety in nursing practice, that is their own and that was provided by other nurses, are discussed. Professional experience was reflected under five sub-themes: *Commitment in pursuit of optimal care for patients and colleagues; Differences in Scope of Practice; Reciprocity in Communication; (Dis)trust and (dis)respect in the workplace and Capacity to learn, unlearn and relearn.*

5.3.1 Commitment in pursuit of optimal care for patients and colleagues

The interviewees indicated that nurses were strongly committed to safety and quality in nursing care provision and caring for colleagues. This theme provides an interpretive description of how the nurses were committed to working together to achieve optimal nursing care. A number of opinions about their commitment were discussed; they focused on their work as a group using individual skills and knowledge to reach the

highest of patient care standards. In doing so, the nurses used concepts such as ‘a good nurse’ and ‘a mother’ to explain their commitment of caring for the patients and their colleagues. Both ideas reinforced their commitment in collaboration in the workplace and identified certain behaviors that were against collaboration.

Michi noted that a good nurse was the one who worked hard to complete tasks, not someone who was neglecting the caring aspects of the role. She emphasised the pivotal nature of collaborative interactions in shared workloads and responsibilities.

> *A good nurse is working hard, caring for patients.* [Some nurses] *chat a lot…gossip and ..//.. do not do the job at all. ..//.. she doesn’t answer the buzzer* [or] *the phone. ..//.. This is not about caring for patients…the patient really needs to sit in the chair. ..//.. but some nurse* [says], *no, the patient is too heavy, give her a wash, (she can) stay in bed.* [The patient] *doesn’t get teeth cleaned and at lunchtime she* [the nurse] *doesn’t set up meals. ..//.. I am ‘in charge’. I have responsibility, so those kinds of things I have to do. I have to work 1.5 times of my workload. But I cannot push because I am in charge I think I have to respect her choice. I feel this is not fair…But I’ve got responsibility you know, to care for patients as well*.
>
> Michi: JN

However, Michi also elaborated how she felt no power; she was unwilling to make suggestions to colleagues who did not behave in responsible ways. She was conscious that achievement of optimal nursing care was dependent on their skills in working together and the development of positive attitudes towards each other as articulated in the CPC.

For Harna, the good nurse had knowledge and skills, was honest and dependable, and able to help others as described in the Competency Standards (CSs) and the CPC. She especially valued those who had the confidence to stand up for themselves. In her

country of origin, asserting herself with more senior peers was unacceptable. The context of practice differed across cultures and countries; the nature of the learning environment also differed in many ways. For example, some more authoritarian cultural traits were less likely to encourage learning from each other collaboratively, but the alternative to this as described by Harna, encouraged respect and collaboration among peers for positive care outcomes.

> *She was so straightforward if you did make a mistake. ..//.. She is honest. For example, if a policy's wrong, if something is wrong she just goes straight* [away to reveal this]. *She's an excellent team leader. She has a charisma. She inspires enormous confidence. She has the knowledge. She's got that charisma which I envy. She's an excellent nurse, the very best, she's doing the best for patients and also if the doctor's doing the wrong thing,* [she] *doesn't care, she just goes straight to the doctors and says so. ..//.. If she thought she gave me too many heavy patients, she just helped me out…without letting me know and she gave a shower and helped me with medications. I think she does this for others too; she is respected by others. I like her so much and* [it is] *easy to work with her. And if you see the allocation book if you see she is on, you're very comfortable. And no matter what happens. You have three or four MET (Medical Emergency Team) calls in the one shift…. You know that this shift going to be OK. ..//… Working together means just helping each other. That's the most important thing in nursing because it is just not being practiced individually…it means you have to work with colleagues together to help the patients out. So working together means helping each other.*
>
> Harna: KN

Like Harna, other nurses, regardless of being OQNs or ANs, believed in collaborative working relationships to do their jobs properly. Jean explicated her belief that helping each other was important for them and treated as an "unwritten rule' for nurses.

> *Whenever something happens in the wards you want the 'other side' to come and help you…if it's a MET (Medical Emergency Team) call or anything like that or even just like an aggressive patient or special 'psycho' visitors that are being abusive to you or anything like that, you want them to come and stand behind you anyway. So it's really an unwritten rule for someone to have to come and step in*.
>
> Jean: AN

Both OQNs and ANs shared a view that nurses needed to work together to meet the professional duty of care towards patients. They also believed that the nature of their work bound them to work as a team. In particular, they suggested that the nature of their work made them collaborative, and teamwork was necessary to conduct their everyday business. There were individual differences that in some instances might have been culturally bound.

The nurses believed that nursing was not only about caring for patients but also caring for their colleagues. They emphasised the importance of a caring working relationship along with clinical competence. Harna discussed her belief about the need to create 'a more enjoyable work environment' for all co-workers.

> *You can be good at pain or, diabetic management, but nursing is more than that. Nursing is not just your job…it is about a caring people, not only patients, but we need to care for each other. To help out is to create a more enjoyable work environment. I think that's the main thing.* [In addition] *as a nurse you have to be really diligent about that aspect; it is about helping others to make*

them happy.

Harna: KN

Harna reported on ‘a mother’ figure, emphasizing care of colleagues.

> *I have a mentor like mum at the moment (laugh). At work, she’s brilliant. She is full of knowledge and full of skills in everything. You name it, she knows everything so I call her mum (laugh). I always say to her we’ve got the same mother but different father we just laugh at each other. She’s like the person* [who looks after me] *and if ever someone started a new career in your ward, you should have someone like her as a friend or sometimes a senior nurse to be a mentor.*
>
> Harna: KN

In fact, Harna had found an AN who nurtured OQNs and assisted them with their socialisation to the Australian context of practice in a manner consistent with both the local Area Health guidelines as well the professional guidelines within the CPC. In the end, they all agreed that the essence of the nursing was about the provision of nursing care to the patient and that they needed to care for each other as they were the providers of that nursing care, with an obligation to provide a professional level of care. The commitments in pursuit of caring for patients and colleagues were presented but with inconsistencies in experiences.

5.3.2 Differences in Scope of Practice

Interviewees identified differences in the way in which nursing is conceived and practiced across cultures and contexts, in Australia and the countries of OQN’s origin. A number of examples of differences were provided here along with examples of subsequent loss of trust of ‘others’ and the extra work that they perceived ensued as an impact of facing these differences and ways to address them. The differences in

workplaces reported centred on nursing procedures, roles and scopes of practice, names of medications, medical terminology, equipment underpinning their work related to patient care in Australia.

Chinese born Bao talked about differences in roles of nurses in managing medications. As an example, her own practice in Hong Kong required a senior nurse to be responsible to hold the keys to a Schedule 8 Medicines (S8) cupboard, however this is not the case in Australia. She was surprised that the responsibility lies with every nurse regardless of a junior or an in-charge nurse. She added how different it was to see nurse managers helping other nurses and asking nurses how they were going, alluding to these behaviours as culturally different.

> *In Hong Kong we couldn't have the big key for S8s. Only the in-charge can hold it…* [here] *on the second day on the ward they gave me the big key: That's strange; offering someone the key, the NUM making the bed with me, and then talking to me asking 'How was the day? In Hong Kong it's different. Most of the time, when I was on the ward, the NUM stayed in the office. They are very hierarchical. They think 'this is student job", 'this is in-charge job.*
>
> Bao: CN

Similar to Bao, Michi, a Japanese nurse and Harna, a Korean nurse, in discussing the scope of 'usual' nursing practice in Australia, highlighted differences in the hierarchical system, and power relationships and levels of influence inherent in different positions due to the hierarchy in nursing, the profession and education. between their new country and Japan or Korea. Further, Dean explained differences in the roles and responsibilities of nursing. He added that he had to learn elements of certain jobs that were the role of allied health professionals or doctors in UK, emphasising his need to learn about the role of Australian nurses.

> [Across Australia and the UK], *Nursing practice itself is very similar. The basic's all very similar. ..//.. there are a lot less services available here in Australia: If I wanted some physiotherapy for a patient I would be able to get that in the UK ED,* [but] *I can't get it here. ..//.. So you* [a nurse] *might need to get someone walking, to get them up and make sure they're safe. That's now a nurse's job here…. It's just another role that roles are changed around over here. For example, over here doctors were putting plasters on whereas in the UK nurses would be doing all the leg plastering. ..//.. There are lots of different things that physios do and nurses do that are changed around. It is a little bit different. You just have to find out first of all who does what.*
>
> Dean: EnN

He also explained his observation of scope of nursing practice with Australian health system being the 'doctor-led' Australian health care service. He perceived this to be both advantageous and problematic in nursing profession. He believed that the doctor led health practice reduced the nurses' roles and responsibility and level of autonomy. He also added that this might lead to less efficient care for patients in the ED.

Just as many the OQNs found, the differing nursing practices from their own country, the ANs also noticed that the OQN's practice was different from their own practice. Bonny explained her experiences of OQNs.

> *I think coming from an overseas hospital it really is quite alien coming into an Australian hospital with what we are required to do - their experience in an overseas hospital is just completely different to what the experience is in an Australian hospital. When they're first starting in basic level and stuff, not necessarily technical things and not necessarily for giving out drugs or doing IV's or things like that, but sometimes just basic things. ..//..a Malaysian nurse was not used to having to do bathing or any of that sort of care so she found*

that quite difficult to do as a part of her work, even though it was explained that that was part of her task to do that. She still felt that it was not the right thing to be doing. She did accept it later

Bonny: AN

Besides those differences mentioned, Suji, an Indian-born and Nora, Zimbabwean born, who worked as a nurse in more than two countries prior to employment in the current facility, provided details on how the use of different names for the same medications varied from country to country. These also differed across facilities within the Australian health care system. Suji who worked in the UK and India prior to arrival in Australia also referred to the use of different reference books for medications such as MIMS (Medication Information Manual System) for Australia and BNF (British National Formula) for the English. Dean, an English nurse agreed with this suggestion and explained how he had to learn about the different equipment when he commenced work in Australia. Joyce also provided an example to demonstrate different use of terminology for medical equipment between American and Australian nursing practice. The term 'IV bung' was widely used for a device that stops fluid flow from one side to another side in intravenous cannulation in Australia, while this same device was more likely called as "IV stopper", or "IV Hub" or IV Port" in America.

Even though it's still English, the drug names are all different. When I first came, I worked at [A] *Surgery in recovery, which was sort of like intensive care and somebody, was asking me for an IV bung. What's an IV bung? I had no idea what they were talking about.*

Joyce: AmN

Joyce also revealed her assumption that the experience of different terminology would not exist as she spoke the same language but the differences resulted in her feeling

intimidated, experiencing a loss of confidence, and sense of annoyance about “stupid little things’.

Interviewees discussed differences in scopes of nursing practice from their countries of origin, in procedures and policies but not necessarily in the fundamentals of nursing. They were focusing on differences in range, breadth and depth within nursing activities across countries and contexts of practice and within their prior education and experiences. These contributed to perceptions of adequacy in relation to patient care outcomes, working relationships, power differentials, and a sense of dissonance for both OQNs and ANs.

The scope of nursing practice they experienced led OQNs to adopt the Australian nursing practice actively and ANs to believe that they needed to support, teach or assist OQNs in the process of transition, hence developed power differential in their relationship like a student (an OQN) and teacher (an AN) relationship. ANs perceived the differences in the scope of nursing practice they identified to distrust and disrespect OQNs in their work working relationship in the name of pursuing an optional patient care. As a registered nurse who met requirement of Australian nursing standards with expectations that they were to competent to deal with an ever changing nursing practice, they were able to deal with the differences they found, but they lacked the ability to do so hence leading to professional dissonance.

The nurses further emphasised how reciprocity in communication and trust and respectful environment is vital for them to work together.

5.3.3 Reciprocity in Communication

The nurses agreed with various professional and organisational documents that emphasised effective communication in the provision of safe and high quality care. In particular, reciprocity in communication was perceived as an ultimate aim of

professional communication desired within working experiences. This was evidenced by Leah's statement; 'nursing is all about communication'. Like Leah, many nurses believed that communication was pivotal to their nursing practice especially coordination of care, collaboration, risk management, professional accountability. She asserted that communication was an equally important clinical nursing skill.

> *You don't know how well someone is if you can't communicate properly with the patient. The patient can't communicate properly with you if the English is not* [good]; *it doesn't matter that they do a great dressing or they can give an IV antibiotic,* [if] *they don't communicate well with the patient. The patient can't communicate that they've got pain or that there's something wrong and they might take blood pressure and that's not good. If they can't communicate to you as the person in charge on how bad or what it is, that's a problem. A normal good communication would be* [in] *handover whether it's from an overseas or any nurse and you walk out of that handover room and know exactly what's happened to my patients today. That's good communication…you can walk out there confidently and think right I know exactly what's going to happen to the patients that I'm looking after today*.
>
> Leah: AN

With the importance of communication in their work, both OQNs and ANs identified English language and communication challenges as one of the most frequently mentioned challenges in their working experiences. The nurses used the words 'language' and 'communication' interchangeably when discussing communication challenges. Many OQNs and ANs believed that if the ability of English language among OQNs especially those from Non English speaking backgrounds was improved, then they could avoid communication challenges. In fact, all OQNs tried to either improve their English abilities or understand the Australian ways to communicate such as use of

humor and jokes and colloquialism. However, other OQNs and ANs pinpointed out that this approach of improving English ability among OQNs to address the communication challenges was not the answer. The nurses asserted that communication challenges should be considered with the complexities that involved in communication.

The nurses then provided examples of complexities that related in communication at work. For example, ccommunication among the nurses in this study was seen to be dependent on socio-cultural aspects of communication such as impacts of culture, power dynamics, the hierarchal system, organisational culture as well as use of humour, jokes, language patterns and pronunciation. Kate included other cultural impacts on communication. Through the following excerpt, she explained that culture, as a set of shared values that people hold, affected how you think and

act and, more importantly, the kind of criteria by which you judge others. Therefore, she asserted that communication should not be seen as a problem, but as a need to improve understanding of each other.

> *You break it down and just talk to staff about people* [OQNs] *who have come from different areas, about their understanding that is very different and the way that we approach things. We seem to be more laid back and laugh about things more. One particular incident I can think about was a girl* [OQN] *accused of being abrupt and not caring with a patient but in actual fact it was just her way of speaking, it wasn't that she didn't care. Understanding of language is a problem because we do use slang and we have a backhanded warped sense of humour; things that we say that we think are funny. When you take them out of the context they're probably quite strange for other people.*
>
> Kate: AN

Others said that the communication issues were not related to OQNs alone, but were also commonly found in nursing practice in general. Jean provided an example of how the structure of the content of the message in handover was a factor for miscommunication rather than English language skills. Jean had observed that AN's communication of large amount of information in a disorganised way, which led the OQN being challenged to comprehend regardless of her proficiency in English. She added that the Australian ways of communicating in the clinical setting were challenging for OQNs as they were not familiar with it.

> *Her* [the OQN] *ability to speak English is fine, she understands it perfectly; it's just the sentence structure .//.. I think about how you* [ANs] *talk. You* [ANs] *just waffle on and not to the point enough …they learn Australian English,* [which is] *full of slang and all over the place*.
>
> Jean: AN

Similar to Jean's notion of Australian ways of communication among nurses, Kate suggested that the normal practice of using culturally situated language and communication styles were concerns for both group of nurses, as they needed to understand the cultural and historical knowledge behind them. Use of jokes and humour when communicating added to the challenges. Nuances embedded in jokes and humour, could be interpreted differently by individuals. Appreciation of this nuance or subtlety was fairly important for everyone concerned to communicate effective and appropriately.

> *Cultural things…. usually like a joking type thing*…[when] *working an Intensive Care there was a* [situation where a] *patient that had arrested…we all went in and did our thing and then when it was all finished the person didn't recover and most people were you know, mortified or whatever, and we just went 'whoops lost another one' and it was just a flippant comment like but it was a*

way of expressing grief, frustration instead of being angry or whatever...but I mean that was an Irish girl so, same sort of thing. I think we use a lot of flippant stuff: I do, all the time. Always getting into trouble. People can misunderstand.

Kate: AN

Another complexity that influenced communication among nurses was some nurses' lack of willingness to listen or to understand the others and stigmatisation of language differences. Michi, using an example of a clinical handover, explained the importance of the reciprocity in communication was vital to patient care provision. When questioned by the AN, Michi struggled to stand up for herself in this case, but this adverse incident made her stronger and she dealt with the AN's response.

I think I'm stronger myself to overcome that kind of issue. I have to survive myself and I think if someone said, 'can you just put me through to someone?' It means my English language is poor and I'm accepting that my ability to go ahead with a conversation is minimised. So I didn't want that. I feel I sort of lost myself so I tried to go step up and push little bit more.

Michi: JN

She also perceived that ANs were not willing to change themselves to address the situations.

Australian nurses cannot change. I think I have to change myself to be stronger and to have more opinion of myself. I think I have to change. We cannot change other people. …//.. I don't think they are going to change themselves to adjust with a person who does have a language barrier. I don't think they have that attitude. The thing is I have never seen that person actually changed because of lots of non-English speaking nurses coming….not many people change their attitude about themselves.

Despite Michi's experiences, some ANs actively sought for ways to enhance their communication skills with an understanding that communicating effectively was critical for them to meet their shared goals of patient care provision. For example, Kate and Bonny used clarification, a simple but important communication skill that could help aid understanding. However, they both acknowledged that use of those strategies to enhance communication was not always utilised by other nurses within their interactions.

As reported, the nurses emphasised the importance of effective communication as fundamental to nursing practice. While some expressed concerns on the English skills of some OQNs, others believed that many factors affected their communication and that the reciprocity in communication was apparent. Reports of communication challenges were evident in the practices of nurses regardless of whether they had been trained in Australia or overseas. The nurses did not mean to take communication challenges lightly as they saw communication breakdown could lead to miscommunication, flawed assumptions, and poor or lack of care coordination. Language for the nurses was not just English language itself, but it was a complex tapestry of nursing profession that requires personal commitment to cross cultural communication and to culture in which they each add their own unique pieces. They suggested effective communication was a skill that could be learned and be continually improved by keen observation, a willingness to be reflective, and a commitment to listen and learn from both parties. Besides this, they asked that effective communication be reciprocal and that socialisation into the 'Australian way' of communicating was an important element of competence for all nurses. They asserted that communication challenges were deepened if these deviated from acceptable use

of Australian language. For example, both the OQNs and the ANs agreed that a practice of using Australian idioms and slang in daily communication in the Australian workplace negatively impacted on their communication. English language ability did not always equate to effective communication. However, the OQNs and the ANs identified English language ability as “a big problem”. Nevertheless, they were able to carry on their day-to-day nursing duties together.

5.3.4 (Dis)trust and (dis)respect in the workplace

Trust and respect in working relationships is important at a personal, professional and organisational level. The nurses discussed creating an environment of mutual respect and trust within elements of roles and responsibilities of individual nurses in different ways while these were seen as a pre-requisite for nurses when conducting their primary responsibility of providing safe and competent nursing care in various documents such as CPC, CE, values of NSW Ministry of Health. In the experiences of the nurses, professional respect and trust differed within the new context of practice.

As discussed in the dimension of Personal experience, Individual differences and not knowing the other in the nurses’ personal experiences meant that their confidence was already shaken when dealing with situations. The nurses’ responses to the differences in professional context further influenced the extent of trust of the other within the professional nursing context. In particular, ANs questioned the competence of OQNs. For example, one of the ANs questioned an OQN’s competence when the OQN did not know certain medical terminology. The term “staghorn” was a colloquial term in Australia while “Struvite Kidney stone” was the medical terminology commonly used for it. Rather than considering this as ‘just’ a difference they found across contexts, this AN assumed an OQN was not competent to work in Australian nursing practice. In addition to having different nursing practice from the Australian nursing workforce, ‘being new’ made the ANs doubtful about the level of competence of OQNs. In the following, Leah,

an AN, explained how she felt unsure of the OQNs' nursing competence and her justification for this. The uncertainty about the OQNs' nursing skills and knowledge existed even when the OQNs had formally acquired their registration as RNs under APHRA.

> *I* [was] *just a bit wary about whether everything's been done. ..//.. They'd never worked here before. Then you would be wary of anyone a lot. You don't' know what someone's skills levels are like because they are overseas RNs*.
>
> Leah: AN

This affected nurses personally but was also an issue of professional responsibility and accountability. Lack of trust resulted in ANs, refusing to work with a particular overseas nurse, and others constantly checking the work of OQNs.

> *A ward culture is basically like this. We don't accept* [OQNs] *being in charge… I suppose (we react by) pushing it to co-workers to take on extra responsibility; they obviously don't respect her* [OQN] *ability to be in charge…(even if) you know obviously she's competent enough…or else she wouldn't be in charge anyway*.
>
> Jean: AN

> *The senior nurses (ANs) were checking her work; what she's done, for the whole shift …because they couldn't believe her ability. Not only the language skills; they couldn't believe whether she was capable of nursing in Australia*.
>
> Harna: KN

So the distrust of the OQNs continued in the clinical setting. Jean, an AN, reported a disrespectful practice that took OQN's role as an in-charge nurses by an AN who were working on the ward as a colleague even if the OQN passed the Australian nursing standards to gain her registration and her manager allocated her to be in-charge. An

RN in-charge of a morning shift gave a handover to another AN in next ward instead of an OQN who was in charge for that ward for the afternoon shift by saying:

> *I'm going to give you hand over for that ward because you know if anything happens you* [AN] *will have to deal with it… I thought that's an interesting aspect of the culture of the ward where you are sort of either undermining the leadership or you are sort of setting them up for failure as well… that's what puts the onus on that person to intercept whenever anything happens anyway with the presumption that you (OQN) can't cope for whatever reason. I mean it sets you* [the OQN] *up for failure. ..//.. it's a self-fulfilling prophesy that's perpetuated within wards…. They (ANs) obviously don't respect you* [OQN]. *I mean there's no point of being in charge, if no one sees you as being in charge. If it's just written there on a piece of paper then legally you* [OQN] *are in charge but if no one on the ward sees you as being in charge then you're not.*
>
> Jean: AN

Beside the perception of ANs, the doubts about nursing competence were related to 'language' as they saw it as the major issue for ANs working with the OQNs who come from a NESB. Thus, the ANs mentioned a tendency to distrust the OQNs' nursing competence if their English language proficiency was not perceived as optimal. In the following, Leah explained that

> *It doesn't matter how good their skills are if their language isn't appropriate. ..//.. if their language isn't appropriate you're not going to see how good (and) how skilled that person is because they're not going to understand what you want…//. It's hard work for you 'cause you're like working for two people. If the language isn't any good, we can't control those people. ..//..They might have passed the English* [test] *but their communication skills are poor, they can't*

> *complete what's asked for them, what a doctor asks, what you ask, what the patient asks for. So that is very frustrating. Cause it's not fair for the patient. It's not fair for you. Then that nurse may face some hostility from you. You're putting yourself at risk, you're putting her at risk and you're putting the patient at risk, all because her language isn't any good*.
>
> Leah: AN

In this way OQNs were viewed as a liability and a threat to patient safety as well as creating extra work and frustrations for other nurses on the ward. In contrast to Leah who felt she could not rely on the OQNs with poor English language ability, the OQNs had a different view. They believed that that they were competent in nursing care provision and were able to work with others to provide safe nursing care. Michi, who reported that her English skill was limited, stated she was confident in communication when working as the RN leading a team.

> *I was quite confident working in S Hospital. I had to do the in charge* [role]. *I had to talk with staff members, managers and doctors. So I gained more confidence with my conversation. I know my English is not perfect. but I can communicate or I can get through what I want to say to them. If I know more English, I can get more understanding when Australian make the jokes and people are laughing instead thinking what are they laughing?*
>
> Michi: JN

Harna also detested the treatment she received and the sense of distrust about the OQNs' professional nursing competence; she said the OQNs should not be treated as 'disabled' nurses as they were the excellent nurses even though they might have limited English language skills. She fought to be treated with dignity as a professional nurse.

> *Because of their English skills, they tend to not to speak English much. They worry about saying wrong things, they worry that the Australian people are going to think they're stupid nurses or something like that. So they're scared. They're not disabled; don't treat them like a disabled person. They may have limited English skills but they're excellent, they have got a lot of experience*.
>
> Harna: KN

Kim made another point. She explained how English language skills mattered to the workplace especially a clinical setting, as English language proficiency and competence needed to be considered together in order to develop trust and build relationships.

> *When they do demonstrate to you that, even though they mightn't have the language, they can competently do the work. ..//.. then you feel more comfortable to trust them with the work. And so the relationship then -- I guess it builds, because I think a lot of the attitude is that ..//.. if the person can't speak English properly that they don't know what they're doing which isn't true. As we know, with the time it's not only the language it's seeing that the person is able to do the job*.
>
> Kim: AN

Kim, an AN witnessed an OQN being transferred to another workplace due to her difficulty to converse on a phone. As Kim was empathic, to the situation the OQN was in and she felt it was unfair for the OQN, as she believed that English language was not the only aspect on which to judge competence as an RN. She also pointed out that there was no evidence in the organisational policy or documents that stated what to do in this situation or to minimise the issues.

While there was an argument about trust or distrust, two of the OQNs and an AN also identified their beliefs about respect. They all believed that working as a team member

effectively to achieve shared goals meant they needed to respect each other. As trust is a characteristic that builds respect and a supportive and safe work environment, different opinions on trust among the nurses were reported with increased tension and negative feelings towards each other with distrust.

While the formal documents require nurses to respect and value different opinions, perspectives of others and knowledge the skills of the other members of the team regardless of their background or their designated position, the experiences of nurses told differently. Bonny, an AN, called for respect of all diversities found in their work.

> *Their* [OQNs] *experience is just as valid as yours is and you have to treat them that way. And that also translates to having overseas trained nurses or somebody coming from elsewhere or outside of your range of experience to, can contribute hugely to what your understanding of just how humans work in general. I don't think it's good to think that your way is the only way and that the way that you do everything is the best if you've got nothing else to compare it with, you don't know whether it is and there could be a dozen other ways of doing whatever that is that are equally as good and effective.*
>
> Bonny: AN

However, there remained a lack of respect exhibited as distrust of the other nurses. Therefore, Harna, an OQN, sought respect from her colleagues with a belief that respecting each other was about fairness, an ability to get along with each other, an important ingredient for all health professionals if they were to work together. She further advocated that protecting each other was also important for them to work together.

> *Teamwork, no matter what your background is, you respect your work colleague. Whether they are ENs or AINs, you need to respect the person as a work colleague. ..//.. they* [OQNs] *have been trained overseas, they studied,*

> *really hard to come to Australia. If they are discriminated against because of their language skills, I think that's unfair. They need to be respected. And everybody has to have the same opportunity. I think that's fair to work together equally, doctor, nurses, assistants, doesn't matter. We need respect. ..//.. that is I think because we are all professionals. And once we get to the work place we can't just be thinking about the patients but the environment in which we help each other.* [We need to] *protect each other. That's something about working together*.
>
> Harna: KN

Bao also indicated that she worked hard to earn respect from others saying, "I work hard and I just respect others hopefully others will respect me" (Bao, OQN: CN). Bonny trusted and respected that all nurses were willing workers.

> *Over the years I've worked with quite a lot of different people...//..I believe most people really want to do their job well and so once someone actually is aware of what's required of them and the job that they are supposed to be doing, most people will get in and do it and do what they need to do*.
>
> Bonny: AN

While there was a sense of a lack of real appreciation of the nature of differences on scope of nursing practice and in the personal experiences, the need to respect the dignity, culture, ethnicity, values and beliefs of their colleagues was acknowledged as important in the nature and extent of their capacity for working together. The participants discussed a need to respect so to protect the rights of others in their interviews and images. While there was an expectation for appropriate behaviour to protect the rights of nurses and despite outlining their beliefs that they needed to care for each other mentioned earlier, a number of experiences of interviewees were depicted as contrary to those ideals. While the nurses saw the importance of meeting

responsibilities as professional nurses and employees of health care organisations, both ANs and OQNs reported unhealthy behaviors in the workplace; what they perceived as bullying and racial discrimination. These behaviors were interpreted as relevant to personal, professional, organisational and socio-cultural levels. The nurses agreed that bullying was embedded in nursing practice, while racism was often subtle and it was part of the experiences of everyday life. Bonny explained this by using a saying 'nurses eat their young". She recalled her experience of intimidation in her junior years as a nurse. She also believed that this practice was not questioned but seen as 'normal' in nursing. She added that bullying was used to "put people in their place" and could be subtle like "being unhelpful and obstructive". She presented her concerns about bullying towards OQNs who did not have enough knowledge or 'know how' at work.

> *I think that* [bullying] *can be extremely difficult as an OQN who already doesn't know, or who is a bit tentative about what they're supposed to be doing already…it's very unkind to treat anybody like that at any time.*
>
> Bonny: AN

Bonny's concern was a reality, as reported by Harna who experienced bullying or discrimination due to personal attributes such as country of origin and language skills.

> *It is nursing itself. Nurses from overseas like Korea or China, are more likely to be bullied because of your English skills. ..//.. In this sense, Australian nurses use the ability to speak English as a means to control overseas nurses*.
>
> Harna: KN

Harna further explained the cause of this bullying toward OQNs as part of the culture of nursing. She was worried about the ramifications of standing up. Harna perceived that a person's attitude and culture of nursing led to the junior nurses' inability to stand up for bullying and unfair treatment around patient allocation. She tried to accept it as it

would be good for her, a fast way to gain confidence once she could cope with heavy workloads. Harna became emotional and had trouble talking about it. While stopping the interview was suggested, she asked to continue. She continuously emphasised the unfair allocation of patients by senior nurses.

> *The culture within nursing… If you stand up for yourself, they don't like you. (That's) a culture of a lot of old nurses. They've got a bit of an attitude problem. They don't like young people to stand up for themselves. The people that like that kind of attitude would probably think you're lazy, too selfish. I don't want them to have impressions like that about me. I didn't say anything* [laugh] *I just did my best to look after sicker patients from the beginning… still it is hard whenever you think about it* [even if] *it has been a long time ago it was hard every day. Some people can stand up for themselves. They say look I am capable of doing this, I just want to have less patients. Some people say that. If they demand it like that they just agree, but behind your back they just don't like the fact and they bitching about you, it's not good. It's really about nursing, the organisation has to change…//.. They didn't care, I couldn't complain because I thought at the time the more I looked after sicker patients I would get more confidence at the end of the day. That's how I overcame unfair allocations of patient* [laugh]. *I was not offended. I could not stand up for myself. I had to do it, to deal with it so every morning, every shift… I ended up having all those complex patients-- that meant you had to survive within that shift. ..//.. I was so lonely at the time. You sort of do your best while you're working so you are just drained at the end of the every shift.*
>
> Harna: KN

Bonny felt powerless towards systemic mistreatment. This practice disempowered OQNs so much that they become uncertain of their 'sense of self'.

There's not a lot that you can do. But if it's something that continues on, I suppose you look at it as bullying and try and do something about it under that heading; try to see if you can get your manager to do something, but sometimes it can be very difficult and this behaviour can continue on for a long time - subtly…very subtle. But that makes things unpleasant and difficult. I had it happen once in particular I remember and that was a misunderstanding and once I spoke to the people about it. I still don't really know why they were doing it to me.

Bonny: AN

Like Harna and Bonny other nurses also felt that the nursing profession and the organisation failed to deal with this, while the effects were detrimental to individual nurses, for incidence, Harna struggled to survive every day rather than enjoying her work. Leah explained how bullying had an impact on the workplace and nurses and was a factor in recruitment and retention.

The girl [an OQN] *doesn't work here anymore ..//.. she was bullied in another ward she worked on….extreme bullying. But we couldn't understand. Her skills were fine; she was a nice young girl. She was a beautiful person and she was bullied where she worked and she used to tell you what happened. So it does happen*.

Leah: AN

Bullying was seen in nurses' experiences as an inhibiting factor for establishment of sound working relationships. As identified earlier, knowing each other, and demonstrating trust and respect professionally were important for their ability to work together. Learning was essential for the nurses to develop trust and to achieve a sense of 'professionally knowing the others'.

5.3.5 Capacity to learn, unlearn and relearn

As reported in chapter four, nurses are encouraged to contribute to the professional development of students and colleagues with focusing on 'lifelong learning'. It was clear that the interviewees depicted this reflective behaviour and lifelong learning in their personal and professional experiences. As reported in personal experiences, the nurses recognised the need to learn about the other so that they can work in an inclusive and respectful way. This learning about the other was required in all different aspects (personal, professional, organisational and social-cultural) to enhance recognition of the need for socialisation, acculturation and acclimatisation.

Learning at a professional level among the nurses in this study was about how the nurses perceived leaning and how they directed the learning while they worked together. The nurses valued opportunities of learning from each other. As reported by Bonny, some ANs suggested that working together with OQNs within Australian nursing practice was a learning opportunity. It was an opportunity to learn about culture and to reflect on her practice about how to deal with diversity in the general community and patients from diverse backgrounds.

> *Learning general skills, just generally getting on with people and that's all a big thing in nursing is when you're dealing with patients is, how you get on with them and to understand that they're coming from a different place to you.*
>
> Bonny: AN

Like ANs, OQNs also valued the learning, this is evidenced in Nora's statement "it is my responsibility to teach my workmate ..//.. that workmates will also teach me". As described by Nora, nurses shared their experiences of unlearning their own nursing practice and relearning the Australian way in a respectful manner.

We used to have sessions where we would sit down and share 'like experiences' and knowledge of all the nurses from Fiji, Philippines, Australia and England. We all got together once in two months. We'd say [to] *educators that we used to do it this, we used to do it this way or that way…and at the end the nurse educators would say OK we can't do this.., we can do this, we can improve this way… we can adopt the British style, we can adopt the Philippine style for these*.

Nora: ZN

However, Nora also reported that teaching or learning did not occur in a way that is normal practice that was expected in professional documents. Asking a question was often interpreted as deficits in knowledge or incompetency, therefore, this action was not always received in a positive way.

People don't always want to do that. After they teach you something, they say 'oh she doesn't know anything' behind her back. In the end, that person mobilises everyone to be against you. It happens to everyone even new grads.

Nora: ZN

However, generally, the ANs asked OQNs to increase their understanding of the elements of Australian nursing practice. The request to "fit in" from ANs to OQNs did include adapting to the ways of Australian nursing practice quickly.

On the whole, we expect people to learn very quickly and to pick up things instantly ..//.. there are so many things that are different and even the culture on that ward will be different, or that area will be quite different from wherever you've worked before and we expect everyone just to pick it up in an instant. Whether they're willing to accept [or not] *this is how we work here and this is how jobs are done or allocated or signed off - I think it doesn't take too long*

before they [OQNs] *fit in ..//.. they're usually very willing to learn*.

Bonny: AN

The OQNs and the ANs both believed that the learning was directed for OQNs to adapting to Australian nursing practice to achieve safety in practices and quality in nursing care in their professional experiences. As seen in the excerpt of the interview with Kim, the nurses who began with a different concept of nursing practice were praised as they became immersed in the ways common to Australian nursing practice. She said

She [OQN] *fitted in wonderfully.* Kim: AN

As shown above, OQNs' adaptation to Australian nursing practices was strongly requested by ANs. To build trust and respect in the workplace given this kind of attitude, OQNs also believed that they were the ones who needed to adapt their practices. For example, Michi, the Japanese nurse, described her account of unlearning her initial beliefs about Japanese nursing practices and learning the Australian way. Here, the Australian practice was portrayed as the acceptable one and adaptation would protect her and ensure her 'fit' within the Australian context. She did not suggest she needed to improve her nursing practice even if she realised this could be the case but rather focused on 'fitting in' and becoming acclimatised to the culture, the ways Australians behave, interact and communicate.

I try to adjust my Japanese skills to Australian frameworks…to work under Australian practice [regimes]. *I try not to do things (the way) I have done in Japan. They aren't needed in Australia; I don't force other people to do it*.

Michi: JN

ANs have also learned from the experience of working with OQNs. Bonny explained that it was an opportunity to learn about culture and to reflect on her practice. By knowing the OQNs, she could understand what she needed to do.

> *I do enjoy learning from them. That helps us to work together 'cause then, I know what I can explain to them, what we have to do, why we have to do it* [if] *they're not used to doing that way, and particularly when if someone's new, you're willing to pick up a little bit more behind them, do some of their jobs that they're supposed to be doing while educating them.*
>
> Bonny: AN

Both ANs and OQNs identified that their working experience with each other within the Australian health care environment was a worthwhile journey in particular by suggesting it was a learning opportunity. There were better working conditions, and overall it was a rewarding experience where they could achieve a sense of 'trusting each other' to some extent when they, especially the OQNs, learnt more about Australian nursing practice. But that took time. This is further elaborated in Theme 4. In the next section, the basis of their collaborative relationships with each other was seen as a contributing factor to the quality of the nursing within the team.

Feedback focused on the professional experience was primarily about perceptions on whether participants worked collaboratively in their practice with peers. Although all of the respondents understood their responsibility as professional nurses was to provide safe and quality nursing care, there was a lack of focus on elements deemed necessary to achieve a collaborative working relationship. The inability to work together was portrayed as lack of understanding and appreciation for what the 'other' contributes to the team. Working collaboratively was being recognised as a complicated dynamic situation; reports of a lack of mutual trust and respect might also have been a barrier to collaborative care. The nurses were working as a group, but the

team was not effectively working together, thus potentially putting the patient at risk and a lack of trust among the team. This is elaborated upon in the theme, socio-cultural experiences.

Reflection: Professional experiences

I realised that these nurses achieved a level of openness, acceptance and respect for each other and that they were undertaking their nursing role in a competent manner. They were 'Being a nurse' in the contemporary Australian context of practice; they had come to 'Know themselves' as a reflective clinician in a novel situation involving elements of a different set of cultural experiences. However, the experiences of each of the participants was different as were their individual journeys, differences in time, place, space and a sense of the person they were.

The nurses did not fully utilise the formal documents: Nursing Standards, Codes of Professional Conduct and Ethics and other policies and guidelines. Nor did I use them to the fullest extent in my work as a nurse manager when carrying out my roles that were designed to assist their acculturation and acclimatisation to Australian contexts of nursing practice.

I was concerned about violation of the rights of others as much evidence was depicted as disrespect of others - bullying and racism and discrimination was evident among the narratives of the nurse's experiences. Further, I was concerned about the judgments about their competence. Some Australian nurses were ambivalent about the nursing competence of the OQNs, particularly relating to their English language proficiency and differences in nursing practice. Others disagreed with their earlier judgment when they became more familiar with the individual. While ongoing learning for the nurses was one of the core elements within standards prescribed for the Australian nurses. Adherence by all nurses to this standard was critical if they were to improve their levels

of professional competence and expectations about professional conduct. The OQNs were learning how to fit into the Australian context but all nurses now as Registered Australian Nurses need to recognise that they are learning on the job about a range of aspects of professional practice.

From my conversation with the nurses, I began to appreciate the value that the nurses placed on their role in patient care. At the time, I considered that the nurses' perceptions of the care for colleagues as part of their roles and functions relating to working with each other were rather limited in a sense that patient care was the most important aspect of their work. This meant some nurses (irrespective of country of origin) were not able to access the personal support required as a matter of priority rather than just adopting ad hoc strategies or undertaking reactive actions. I was conscious of my assumptions prior to commencing interviews where I had assumed that caring for each other was equally important as that which underpinned care for patients in their daily practice.

5.4 **ORGANISATIONAL EXPERIENCES**

Organisational demands, culture and structural processes acted to either support or impeded how the nurses worked together. These organisational experiences are reported under themes: *Collaborative practice, Creation of a helpful environment and Supportive leaders.*

5.4.1 Collaborative practice

Collaborative practice to meet the professional and organisational demands was identified in reports of the nurses' experiences. They explained the collaborative practice from many different perspectives. As evidenced in the following excerpt,

nurses explained the importance of developing working relationship to achieve their responsibilities to provide optimal nursing care. Harna emphasised working relationship as being caring for and supporting each other as well as helping the other to complete nursing tasks even if the choice was personal.

> *You think about the relationship ..//.. we show them we support them ..//.. Working together means helping* [the other nurse] *the physical aspect of nursing as well as emotionally. You need to show someone you care about* [them], *your work colleague is important in nursing*.
>
> Harna: KN

The nurses provided reasoning for their collaborative practice saying it was required to meet the organisational as well as professional demands. The demands and volume of the workload caused them to work closely together regardless of other negative practices mentioned earlier.

> *It's extremely busy… big colorectal general surgical ward. So* [you need] *to work together ..//.. a lot of the time, the staff here work together as a team*.
>
> Leah: AN

> *If I have a very heavy patient and other, nurses come to me and ask 'do you need a hand?' They just give me hand….I do that for them as well. We had a MET call last Friday. Then (the nurse) had to look after the patient, just for a day. She couldn't look after other patients. So I had to look after some of her patients as well as my patients*.
>
> Soon Hee: KN

The nurses also depicted developing collaborative working relationships, different from the experience of developing a personal relationship mentioned earlier. While a lot of views and reports about the difficulties of being included and factors that contributed to

the development of inclusiveness among the nurses, the interviewees indicated that both OQNs and ANs valued the development of collaborative practice to meet work demands. In doing so, the nurses talked about two ideas: 'getting along' and 'being connected' in the same manner they discussed inclusiveness around interpretation of organisational policies and procedures. However, these ideas were closely related their work relationship to achieve patient care, while inclusiveness referred to personal relationships.

Jean suggested 'getting along' in collegial relationships implied communicating, resolving conflicts, and helping working together within the organisation while connectedness centred on work friendships where they shared experiences of matters not directly related to work, but including negative work experiences.

> [Getting along means] *you can communicate… you can rely on them to help or you can help them. You read their body language and you can see them and you know when they're stressed and you can say to them 'What's wrong? Do you need a hand?' and they might say 'I'm having a problem with that nurse down there. And you go 'all right I'll go down and see what the story is'. I'll give them a hand. You demonstrate to them that you can relate to them and that you can help them with their problems. So I suppose it's an intermediary type of thing. When you connect with anyone, we talk about how we were doing further education on respect for each other. Where we were connected was the fact that I appreciated what she was doing and I was completely in awe of what she was doing. And at the same time we just sort of look out for each other. We'd talk about how you are going with your studies or sharing the experience of being on this ward was completely horrible.*
>
> Jean: AN

Harna further explained how she believed the ideas of being included, achieving connectedness and getting along were inter-related in organisations. As suggested by Jean, Harna valued both getting along and connectedness; these attributes helped them to have good working relationships among individuals and 'knowing the other' helped this process.

> *I can connect and get along.* [It is] *like you develop a friendship between you and nursing colleagues…connections and getting along go together. If you have someone who is connected, that means, most of the time you can get along while you're working together ..//.. build a good relationship. When you've got a good relationship with workmates, "getting along" just comes naturally. Being connected and getting along are pretty much the same thing. If you're connected with someone, if you know exactly what the person is thinking, you know exactly what your work colleague is going to do next. Then you don't need to think about anything because you know the person…you are automatically connected. While you're working, that means,* [it is to] *get along together*.
>
> Harna: KN

While Harna, in this excerpt, explained that how she felt connected with the ANs as she had been working at Australian workplace for some time, she felt that the ANs did not try to be connected with OQNs, rather, focused on making complaints against or stereotyping OQNs.

> *Because I've been working at my work for so many years now, I feel connected to most of the people. That means 99 percent of the time I don't have any trouble. But I heard a lot of complaints about overseas nurses in the other ward. I feel really so bad. I don't know whether you can just judge the person because they don't have good English skills. Some people* [ANs] *even*

don't try to connect to overseas nurses. They sort of get a prejudice about the person. That's a kind of barrier. The person can't speak English properly so she/he is probably stereotyped. All the nurses from the overseas think they have to be careful with ANs. Even you can't speak English properly, you are able to connect with the people. You can also get along. They [ANs] *have to be patient and try to give them time, and find out who they* [OQNs] *are as individuals. They can make changes in relationships.*

Harna: KN

Other nurses also described way of collaborating on practice as 'a good shift' or a terrible shift'. These two concepts were related to a belief that meeting organisational demands such as completing their workload and patient care were important for their work. Kim referred to a 'good shift' as completing the tasks of nursing care saying "what we are looking at I guess is basically getting through the shift with all the work done…and the patients happy and well looked after and all their needs being met and being done properly" (Kim: AN).

Jean explained that the association between these collegial relationships and having a good shift was clear and explained that as long as the job was done the nuances and differences expressed within the personal relationships and features of communication on matters other than clinical issues did not matter. These views may not have been underpinned by ideals that incorporate a need to display professional and organisational values suggesting acceptance of cultural differences.

You don't have to get along with people to work with them, you can still work with people. ..//.. [If] *you just don't connect with them, there's nothing you can say or do. So you sort of think that you're going to have a completely terrible shift ..//.. it's just like a personality clash. And it's just the way it is. You might have issues ..//..you don't want be here, you don't care, you are just there to*

do your job you are going to walk in do your job, that's it and walk out. You are not going to relate to anyone except this person that you worked with for eight years who you get on with. ..//.. There's nothing that I'm going to do or say that's going to make you laugh, smile or acknowledge my presence. Therefore it doesn't matter. I'm not going to force myself. I could still have a good shift cause I know you are competent and you will do your job and I'll do mine and everything will flow smoothly. ..//.. I don't care cause I don't want to go for my break with you cause you obviously aren't going to really communicate and that's it.

Jean: AN

Jean further explained her views on the notion of a terrible shift that was about being unable to meet organisational demands due to a lack of communication among workers, no evidence of teamwork, and no one willing to take responsibility to lead the team. This might cause a medical error, adverse events or accidents. She said there are:

…terrible shifts where no one is communicating, the medical team is coming through and asking questions [but] *are not answered* [readily] *so they project it on you cause you are stupid enough to look at them. You know that type of thing and there's the NUM saying get your discharges done and no one's kind of working together as a team, or the person who is supposed to be in charge just disappears. That's a bad shift. Where people ..//.. you just can't communicate with and you're trying to tell them something look I've got to go and do this, and this for my patient and they'll just cut you off and not listen to you.*

Jean: AN

Nurses valued collaborative practices in their organisations, but various patterns in collaborative practice were identified. This collaborative practice was very much related to their commitment in pursuit of caring for patients and colleagues that was discussed in the professional experiences. Nurses further emphasised how a helpful environment is vital for them to work together.

5.4.2 Creation of a helpful environment

Creation of a helpful environment includes an appraisal of reports on how the nurses evaluated the organisational environment and its effect on them 'working together'; Consideration of support programs to enhance their work is included. OQNs and ANs pointed to both positive and negative environmental factors with greater emphasis on the negative aspects.

As seen from Michi's interview, a number of OQNs, unlike ANs. mentioned positive aspects of working conditions in Australia such as better pay and better work health and safety.

> *I think the Australian nursing system is better than Japan. I don't want to go back to Japan to work as a nurse...it's too hard. In Japan we have to work sort of overtime, non-paid. Here we have more holidays: We can finish work on time, I can go home on time. Working conditions are a bit better. Regarding occupational health and safety, there are more regulations,* [that is] *to support nurses. So I think working conditions are better here. People ask me "why did you come to Australia?' Japan's a good country but actually I don't want to go back home to work*.
>
> Michi: JN

However, OQNs and ANs wanted a better working environment to assist them. First, they perceived the Australian health care system was unjust towards OQNs. This

perception was due to the fact that the nature and extent of OQNs' qualifications and previous experiences were not fully appreciated or acknowledged. Like any OQNs from NESB, Harna, a Korean nurse with a two years' experience needed to complete a year-long conversion nursing course to gain registration as a nurse in Australia. This was to enable her to be aware of the differences between South Korean and Australian law, codes of ethics, scope of nursing practice and other components of the educational preparation for a registered nurse. The course, a pre-requisite for employment by the organisation is designed to assist OQNs to acculturate and acclimatise into the Australian health care system and society. As evidenced in previous themes, however, OQNs were struggling to adjust to the Australian work environment, which creates to doubt about whether those courses were effective in the OQNs' acculturation and acclimatisation at work.

Nevertheless, OQNs are often employed as new graduate nurses in tertiary hospitals when they complete their conversion course, creating a situation where they are positioned as beginning nurses. This designation of status in the profession in Australia was queried by OQNs themselves and ANs like Jean.

> *It's interesting 'cause when you look on the roster it might say that they're an RN1 or an RN2. But they're not really an RN1 or an RN2 in their own country. They're RN8 and thereafter. It's just that they've come to Australia and they've been put down in that level. I think that most of them are extremely experienced. It's wrong. I don't know how they make their decisions*.
>
> Jean: AN

While Australian authorities had judged the preparation for practice for Harna in South Korea reflected a different 'scope of practice' to that common to Australian contexts of practice, Jean believed the extent of some experiences of OQNs was not recognised and pointed out that there was a lack of policy to acknowledge and support recognition

of their prior experiences. In addition, as discussed in the previous themes, OQNs like Harna still struggled in the Australian work environment with differences and one-way adaptation required of them. Nurses described an unhelpful environment with unrealistic expectations of OQNs at work. In spite of being designated as junior nurses, the OQNs were expected to work as experienced nurses from the beginning. Harna explained how OQNs were expected to be 'perfect from the beginning'.

> *But* [perfection] *can't be* [achieved] *from the beginning at all. We need support. We need it from our work colleagues, otherwise we can't survive because of our English ability if they keep bullying us constantly, we can't survive here*.
>
> Harna: KN

The 'time' factor' was also a central feature as all nurses attempted to fulfill their need for developing a better appreciation of 'the other' in the workplace. As Dean, with one and a half years' experience in the UK suggested, he was not ready to take on the responsibility given to him at the early stages of his working life in Australia.

> *I've been left in charge of the ward, the department and I've only been there just under a year and a half; I'm a junior nurse. And they leave you in charge. Well it's really difficult because I don't know everything and I certainly don't know everything here in Australia. I didn't know everything back in the UK. It's pretty daunting and I didn't expect to be put in that position this quickly*.
>
> Dean: EnN

Time to acculturate and acclimatise was seen as necessary to adjust to the workplace environment regardless of experience in other contexts. Nora, with 5 years working experience in Zimbabwe and a year of experience in other health care systems in Australia, explained that how she was expected to be 'in-charge' before she had time to learn about the usual nursing practice in the current health care services.

> *It was pretty hard when I started. I was at Level 6 and there were many people in the ward* [at] *Levels 4, 3 and 2 and so when I came as a Level 6 nurse,* [they think] *you should know everything. Yet I might have done a bit of urology but I was in a small hospital so wouldn't do much and then I would be 'team leader'. But being a team leader doesn't necessarily mean you know everything, do you know what I mean? You can have a new grad knowing stuff better than you so all you needed was to share information but people just thought your were team leader you should know it and I found I wasn't getting a good vibe from those I worked with*.
>
> Nora: ZN

Both Dean and Nora were surprised and concerned about the responsibilities put on them. The ANs explained this was due to individual nurses' expectations of OQNs, the nursing culture and organisational demands. ANs indicated that they expected OQNs to be ready to take on nursing duties and responsibilities as RN as soon as they commenced. The ANs usually saw the OQNs as a RN with Australia nursing registration with many additional years of work experience as qualified nurses in their home country. Therefore, ANs expected OQNs to be experienced nurses who were able to carry out their nursing duty without much of a transition period. The ANs soon found this was a misunderstanding and showed a lack of consideration for an OQN's need for adjustment to work in a new place and into new sets of practice expectations. Bonny described how the Australian nursing culture of "see one, do one and teach one" influenced expectations for OQNs to be at the state where they would adjust to the workplace quickly.

> *We have this expectation of, 'we've shown you once, you should know how to do it now … I still think that we expect people to learn quite quickly and pick things up very quickly. ..//.. see one, do one, teach one ..//.. straight away, you*

can be shown it once, you do it once and then you should be able to pass on your knowledge the next time you do it. Probably, they were thrown in at the deep end themselves; this is what they were [expecting of others].

Bonny: AN

The OQNs, irrespective of country of origin, said they needed a helpful environment to adjust to Australian nursing practice. Australian culture and organisational demands meant meeting that need was not possible. In addition, the nurses identified the need for organisational support strategies such as orientation and educational programs and elements of leadership. However, most of the nurses clearly identified lack of organisational support in that limited education or orientation were provided, further some of orientation was inappropriate. Nora from Zimbabwe stated that there was not enough support within orientation and personal support measures.

I found that I didn't get enough orientation in the ward because it was that busy and so there was no one who could really sit down and work with me ..//.. I had to find my way out.

Nora: ZN

Harna also explained that there was no direction to follow on arrival so she was left alone to figure out what to do to survive. The lack of orientation for the OQNs led them to limit the routine practice at workplace as discussed by Kim, who believed that an orientation program was a little thing, but it could address a lot with it as evidenced by a statement of "spending a bit of time sorting out those simple, it's the simple things. it's just those little things''.

In addition, Nora highlighted how an OQN with six years' experience and a year working in another state of Australia was assigned to be orientated by an Enrolled Nurse.

At the first hospital, I had someone who was just allocated to orientate me. I'm a RN [but] *I was given an EN to orientate me. She couldn't show me much. .I'm sure she sort of felt I was going over her you know what I mean, yet I wanted to learn from her. She couldn't take me to the DD cupboard she couldn't take me to certain places. You need to know about the paperwork as well* [for] *admission, but I only did patient care for that day, I didn't even know the paperwork and when it was time for me to do hands on…*

Nora: ZN

She saw this as a discriminative practice indicating she was not competent as an Australian RN. She expressed resentment and unfairness about this as a number of duties of RNs, such as incident management and medication management were not part of the orientation as they were outside of EN's scope of practice. Subsequently there was a power differential that developed and this created a difficult situation where there was ongoing conflict.

Other OQNs further explained the lack of and inappropriate systematic strategies to support nurses in general. Joyce, an American nurse at operating theatre and Dean, an English nurse, at the ED explained how they orientated themselves of the workplace using provided booklets or learning on the jobs for clinical procedures and policies.

We got a booklet at orientation. I couldn't have just gone in and been expected to know the instrument…We have to go in the job and learn what's going on. [It] *would have been a lot more hopeful and have eased the transition a lot if there was some sort of education…There wasn't very much education as in formal education coming in. Considering I came to a completely new specialty, its like being a new grad, really and there was no clinical nurse educator at the R ward... at that time, so I was dependent on the scrubbers that were*

mentoring me or training me for that day to tell me all the little things. And I feel like I missed out on a lot of those little things ..//.. I didn't have any of those classroom sorts of formal setting with theatre.

Joyce: AmN

Like Joyce, other OQNs pointed out the lack of further education at work. OQNs stated their unmet expectations for continuing education to support their acculturation into professional practice including policies and procedures and competencies expected in the organisation.

Lack of orientation and education caused challenges in conflict management and decision-making through confusion among the nurses over the boundaries of their roles. Sharing and agreeing on goals were considered by interviewees as fundamental to good decision-making, but the working environment and differing perspectives made this difficult to achieve. Further, differences in the decision-making processes and incident management decisions led to conflict between OQNs and ANs. While the management of adverse events was part of a role for nurses to ensure the quality safe care, the nurses did not have knowledge that was practice based and related to the infrastructure to support patient safety and making clinical decisions using evidence-based standards. In Nora's narrative, she explained how she felt that professional judgment has been degraded in this incident management when she was working as a team leader.

When I was a team leader, I didn't like what happened. There was an EN who gave an S4 drug on her own. I think she just didn't know..//..Another nurse discovered it and she told me [about it]*. I phoned the after-hours manager about how do I handle this. She* [after-hours manager] *said 'just take those drugs and lock them up in the cupboard and then speak to her and tell her this is a drug she isn't supposed to give'. But that nurse* [another EN who

> discovered the error] *wanted that girl to be punished so she came back and she said 'did you speak to that nurse?' and I said 'yes" and she said what did she say and I said this is what she said and she said OK. I don't understand why she would say that. Because it's a very serious case, She gave her the wrong dose. She did something wrong according to the hospital policy. She* [the EN who discovered the error] *called the nurse manager and she talked to the nurse manager ..//.. The nurse manager rang (me) back and said 'put it an IIMs* [Incident and Injuries Management System] *.//..* [I] *was overstepped by another person (who was an EN)*.
>
> Nora: ZN

As she was the team leader and she managed the incident with the advice that provided to her by a senior manager, she could not accept the EN's confrontation on her actions. Nora was comfortable to manage the nurse without involving a formal reporting system such as IIMs (Incident Information Management System), whereas the EN who discovered the error believed that an incident should be managed through a formal system and she was right according to the incident management policy of the organisation. As a new OQN with lack of knowledge on the topic and incorrect advice from a manager, Nora felt undermined and distrusted when her management of the incident was challenged by this EN.

OQNs with some ANs identified that orgranisational support was crucial for them for acclimatisation to a new nursing environment and work practices. Nurses identified supportive leadership as a vital factor for working together within the organisation.

5.4.3 Supportive leaders

Support from nursing leaders such as clinical nurse educators or nurse managers were seen as important in dealing with issues raised and creating a supportive working environment. Numerous documents demonstrated that supportive leadership is crucial

for performance and collaboration. A number of participants felt that they had experienced support from their nursing leaders. As discussed in the personal and professional experiences, nurses, especially OQNs felt that some managers were responsive and sensitive to their needs. These qualities were a focus of ANs in supporting both ANs and OQNs. Bonny and Kim explained how they relied on the managerial assistance when they needed support to work with OQNs.

> *I would certainly go to my manager and the educator when I don't know what I would do.... Where I am at the moment, both the manager and the nurse educator have been very supportive and we've looked at, as a group, the senior people there, what we can do to put in place to help these* [OQNs] *people who have clearly been struggling. It is good and it's nice that that happens*.
>
> Bonny: AN

> *We mentored her* [OQN]*, buddied her up with people. Our nurse educator came in and helped assist her in that way. That worked really well. It's really good that the hospital has those systems in place…if you find a problem, ring someone to get the information*.
>
> Kim: AN

Both Kim and Bonny believed that support was available for OQNs, but this is contrary to the experiences of OQNs discussed earlier. Further, they did not embrace the notion that there were existing guidelines that might help them personally with interactions with people from other cultures. Regardless of this, many ANs continued to look for managerial support when there was a need to address a problem.

> *The Nurse Unit Manager can either talk to staff members or ring our staff educator who's fantastic, a very nurturing person, she would always find solutions and often it was just a matter of a bit more education on certain*

things. But certainly with the language problem I guess…with a patient you just naturally jump in and help the nurse explain what they're trying to say because usually by that stage you know them and you can understand their language and a little bit more, so you understand what they're trying to tell the patient. You just automatically will say you know this is what she means... And then if that doesn't work I guess it's going to the NUM.

Kim: AN

Kim did not see that she personally could become more culturally aware through education, but she requested leadership support to manage nurses from different cultures. She detailed the need for financial support to have personal support such as nurse educators 'who could come up and tell us how we can help them individually'. She then said about her need to increase understanding of culture such as culturally appropriate managers and support strategies she could employ. Kate emphasised the importance of culturally competent mentors or support persons. This is crucial for nurses, especially ANs looked to leaders for direction on what to do when they faced issues while working with OQNs.

Mentoring needs to happen, it does on paper but it doesn't in reality. I mean I think a lot of it people talk about it. For example someone who is foreign trained, working on the ward and has an issue, who do they go to? I think there should be some sort of backup for them. People will say talk to your NUM but if the NUM is part of the problem, you are not going to do that. And [there] *is fear of hierarchy. If there's a problem between the overseas and ANs you know who are they going to go to because if they go to Australian NUMs… It's not really a level playing field. So I think there needs to be some sort of mentoring, clinical supervision,, somewhere that's neutral* [where] *these people can talk about issues because I mean they must be there because well*

you know yourself if you go to a workplace there are always issues… it's how you deal with them whether they become big issues or little issues. And I think if someone's feeling uncomfortable about something they need to just go and bounce it off somebody, talk about it and then go back and try and sort it out but I think not everyone can do it on their own.

Kate: AN

Managerial support was an important aspect that impacted on experiences of ANs and OQNs. Further, the nurses identified the importance of manager's attitudes and responses in the experiences of nurses being either positive or negative and potentially deepening the reality of their experiences. Bonny and Kim described how supportive leadership to manage the diversity was important for OQNs and ANs to create an environment conducive to optimal patient care achieved through collegial, goal oriented working experiences.

People are guided by their superiors, so if their manager has that attitude, then that's going to pass down…as a first year RN, my very first NUM told me I wasn't allowed to do the work or help the junior staff. They had to do their own work and even if I had time from my work to help them I [had] *to stand over them and make sure that they did it. That was my job. They were supposed to know what they had to do and they had to do it*.

Bonny: AN

Because she fosters that sort of culture in the workplace. She won't tolerate any bullying. She won't tolerate anyone excluding someone. So I guess because she's setting that example to all the staff of nurturing the new, whether it be a new graduate or a staff member from a different culture she models that behaviour to all the staff that they have to be nurtured and helped.

The findings around organisational experiences were presented and reflected nurses' experiences on how different relationships emerged to meet organisational demands and showed how organisational and leadership support for workplace diversity were vital for nurses to work together.

In themes depicting the personal, professional and organisational experiences, a number of socio-cultural factors, issues, and behaviours were influenced nurses' experiences in those dimensions. Participants identified diversity within race, language, education, working experiences and country of origin impacted on how nurses perceived each other and how they worked together in the workplace. Exploration of on socio-cultural experiences will provide additional detailed understanding of the nurses' experiences related to the wider Australian community.

Reflection: Organisational experiences

I was surprised how some of the nurses perceived that supporting the OQNs and attempts at conflict resolution were the responsibilities of the managers and others within the organisation. They did not feel that they personally had the power to offer support. They relied on others in leadership to address those issues that were right in front of their eyes. In addition, some support mechanisms were already available but making the most of these was not seen as part of their role; solutions and resources were not utilised by the nurses in an effort to improve acculturation and acclimatisation of others to their workplaces. For example, they could have used the policies such as those respectful workplaces or the standards of nursing as the basis for conversations about dealing with bullying or racism or unsafe nursing practices in a respectful manner, but these were not visible, were not part of orientation and thus nurses did not

fully embrace them.

In contrast to the descriptions of 'avoidance', some nurses' descriptions of supportive managers provided evidence of abilities that are conducive to respectful workplaces. It was however, disconcerting that other nurses reflected on their experience that suggested their managers were not supportive. Those nurses perceived that they were focused on the patient care only with a "sink or swim" mentality for staff members. This might be a reason that the nurses who were in a need of support or management's input didn't take action to get support from managers. These examples presented a paradox for me as I was beginning to appreciate that the nurses needed the support of management, yet they themselves showed an inability to seek the support when they needed it most.

5.5 **SOCIO–CULTURAL EXPERIENCES**

The dimension of 'Socio-cultural experiences' highlights nurses' experiences of being within the health care setting that is part of the broader Australian culture and the wider Australian community. Their experiences of each other and the patients and families were influenced by the norms within society. While there were a number of references to sociol-cultural influences in the reports on experiences of the nurses personally, professionally and in the organisation, reports of experiences in this dimension convey greater appreciation of how cultural values and norms influenced the nature and extent of management of the diversity in their workplaces. A number of experiences are reported on because these had to capacity to enhance or limit their working relationships and the manner in which acculturation and acclimatisation occurred for individuals. Socio-cultural perspectives are featured under the subthemes: Nature and extent of *embracing diversity and Time for appreciation of the other.*

5.5.1 Nature and extent of embracing diversity

Interviewees expressed a number of concerns related to differences that were evident within the group, rather than celebrating the diversity as indicated in the *People of Australia and Multicultural NSW Legislation Amendment Bill 2015*. In addition, the ICN statement inspires celebration of cultural and linguistic diversity and encourages management of that diversity as a core element of competence of RNs. The interviewees reported being together was a novel situation, representing the 'unknown' for them as they realised a number of differences existed. Their lack of knowledge about each other's culture, past nursing experience and nursing practice, affected their working relationships and led to problematic interactions even if they had the positive intentions to act properly in a multicultural context. Therefore, while the nurses were required to create and maintain cultural sensitivity and social responsiveness in their practice, their lack of confidence to respond to social and cultural differences being problematic for them was evident in self-reports on their personal, professional and organisational experiences. Nurses also reported how the perception of the diversity within Australian society and culture influenced their experiences as nurses. In the following excerpt, Kate explained how racial differences were perceived and categorised people into 'us and them', hence developing 'the other' rather than accepting each other.

> *I think it comes down to a cultural thing about our 'ockerism'. I suppose you know the* [notion of a] *superior race and...It's still there. The White Australian Policy is still* [part of people's perceptions], *not only necessarily in nursing but I'm also thinking the white Australian will still put other people down. Be it at football matches, be it whatever and it's 'in-bred'. Look at all those Cronulla riots and all that stuff down there with the Muslims. If you met them one on one, it would be fine but because they have their little group of their own, their own*

beliefs and things, it becomes a 'them and us' thing.

Kate: AN

Kate then explained there was lack of acceptance of different cultures and how the White Australian Policy still impacted on people's attitudes. She pointed out that there was less likelihood of acceptance towards OQNs from certain parts of the world, especially from Asian countries, in the workforce. Kate viewed that it is a comment on how Australian society responds to newcomers.

We, Australian nurses still have a way to go in the acceptance of other cultures. It is much better, but I still think there's room for more acceptance. Because [we still think] *if it's not Australian it's not right. If somebody else comes from, I'm thinking about Malaysia, Indonesia whatever, you can straight away see some of the people hackles rise, go like 'here is one of these foreign trained nurses'. I still think we as a culture have a long way to go.*

Kate: AN

Harna requested acceptance from ANs indicating that OQNs put effort in to be accepted.

If Australian nurses do not accept it, it's not going to happen. The attitude of the Australian nurses can be really important. They should be accepting. I want them to recognise that we really try hard. ..//.. Australian nurses need to be more accepting. And I hope they understand our background.

Harna: KN

Some nurse managers more readily supported OQNs when there was unfair treatment from patients.

Some patients are not polite, very rude at times. Then the manager came in. She called a social worker and she's very protective of me ..//.. she's told me

don't worry about anything's like that, taboo…Very supportive of me.

Soon Hee: KN

The interviewees described this community attitude that filtered into nurses' reports of racism in the workplace. This behaviour deviates from numerous anti-racism policies including the NSW Health's Respectful Workplace document. For example, Dean, an English nurse reported that health care staff's racist behaviours towards patients and the nurses from different races like Aboriginals and dark coloured skin in the culture of workplace.

There's definitely an undertow in Australian society in general with racism..//.. towards other non-Australian, non-white races. ..//.. Because in the UK it's very multicultural and it's everyone kind of treats everyone very similarly. Whereas over here I think they are just a little bit behind where the UK was.

Dean: EnN

On the existence of racism, Leah was concerned about an OQN who was unfairly treated by a patient due to different coloured skin and language.

They [OQNs] *are targeted by the patients. In some cases, especially by older Australian men, they're not treated very well sometimes. I don't know whether it's a cultural thing or it's just society. People sometimes complain,* [but] *that nurse hasn't done anything wrong. It's just that culturally she's quiet; she goes about her work. Just because she's not fair and English isn't her first language…* [it] *doesn't mean she's not doing the right thing*.

Leah: AN.

Nora believed that racism was evident in a subtle form everywhere; therefore, it was difficult to see it as racist intent rather as a person's attribute at times.

It would have been indirect but ..//.. I noticed it. It's there. Because racism is not encouraged in workplaces even if people do have those feelings towards you, they wouldn't really show them directly ..//.. but [it is] *racism*.

Nora: ZN

Nora pointed out that the ineffectiveness of the anti-racism policies at work; they stopped the racist behaviours being visible, but assisted them to go unnoticed. Some other nurses also discussed the difficulties to discuss racism, as they did not feel safe to do so. In contrast, bullying was freely discussed as they accepted that it was a culture of nursing. However, Some OQNs faced what they perceived was disrespectful behaviour at work. Acts of disrespect were recurrent and normalised, infused into familiar practices such as conversations, including jokes and behaviour in nurses' working lives. It was embedded in routines and everyday practice. Bao provided an account of her experience of subtle racism during the interview.

One person has to go to the kitchen to get supplies like milk. I was the one to do it sometimes. I was late to getting to the kitchen that day. There was a queue, I was very persistent. I said I needed to get those things back to the ward. Then the kitchen staff [said] *'oh, all right…this is an exception all right. I'll get you those things.' And then, although I was late for that opening hour, I was still able to get all the milk and bread and cheese supplies back to the ward. Then one of the Australian staff* [asked] *'oh, Bao, that's great, how come? I said 'yeah I just stay there'. And then, she say 'oh, did you just pretend you don't know English? And I just laughed. I don't know why she just thinks that is a joke. I don't know.*

Bao: CN

Bao tried to make light of the incident and tried to receive the remarks as a joke, the AN's comment "did you pretend you did not speak English?" While the incident

devalued Bao's ability by undermining her negotiation skills, Bao did not stand up for her rights or explain how she achieved the positive outcomes even when there was a "Racism in the workplace, it stops with you" campaign that was ongoing along with other policies related to racism in the workplace. Bao also talked about another occasion that was similar, but she did want it documented. As she talked about this incidence in tears, it was clear that these experiences were distressing her.

Attempts at management of diversity in the Australian community and in Australian nursing workforces had failed on occasions to protect the rights of the people whether they were patients or ANs and OQNs. Interviewees stated that fitting into Australian culture was the way to address challenges arising from societal diversity identified by both ANs and OQNs.

In addition, along with bullying, racial discrimination took a toll on the individual nurses' welling-being, levels of satisfaction, and experiences in providing patient care. Lack of acceptance and racial discrimination towards colleagues within the organisation are inconsistent with the requirements outlined within the CPC, HNE and NSW Health and other documents that reflect what is expected of Nurses. While the nurses realised that racism was prohibited at work, some racist discourse, discrimination and bullying were reported. Nurses were confronted with the complexity of dealing with people from other cultures and a diversity of races. Racist views and behaviours were expressed overtly or covertly depending on the situation. Given the policies and regulations that prohibit racism in health service workplaces, the nurses did not spontaneously talk about racism and avoided discussion about race in their initial conversations. Hence, it seemed to the researcher there was a 'race-less' workplace as the nurses feel that they should not discuss race or racism. However, interview respondents reported that what they called racism had detrimental effects on them and this led to negative interactions; most failed to prevent instances of race bias in interactions with others.

The silence around racism in the workplace also caused the nurses to feel powerless to address racial injustice. While the nurses were ethical and apparently logical about their attitudes and actions towards differences, even saying “there is no racism” or “I am not a racist”, the ANs and the OQNs frequently discussed their experiences of witnessing prejudice and discrimination from patients towards OQNs, which derived from racially orientated or racial difference. Thus, some nurses’ working relationships were somewhat tainted by racial discrimination. Meanwhile, the OQNs avoided talking about the issue, avoiding acknowledgment of “racism” to protect them from getting hurt or humiliated, keeping harmony in an effort not to aggravate the situation. Although the expectation was that nurses should speak up for unfair and unjust behaviours, both the ANs and the OQNs felt they were not able to speak out or to challenge the unprofessional behaviours.

Another reason for not speaking out is because the racist behaviour often occurred in subtle forms and in the form of ‘everyday racism’. The situations that counted for racism were expressed as “uncomfortable situations” rather than racism. The ANs were concerned about being called a racist person and in some cases; this concern prevented them from speaking up when they felt there was a risk of reducing the safety and quality of care. One of the ANs even mentioned the existence of a “reverse racism” in their experience. They also agreed that racism was embedded within individual nurse’s behaviours but also among members of the wider society. Racism was often silenced by the OQNs and the ANs and only referred to in a rhetorical sense as someone else’s issue.

In contrast to racism, the concept of bullying was discussed without hesitation among the nurses. The nurses frequently explained that bullying was embedded in the Australian nursing culture; hence, this gave them permission to talk openly about it. Racism was occupying a silent space whereas labelling some behaviour as bullying

was indicative of a more comfortable space and a topic the OQNs and the ANs could talk about. It was evident that there was a normalisation of bullying within the construction of the reports by OQNs and the ANs about their working lives.

5.5.2 Time for appreciation of the other

This subtheme, 'time for appreciation of the other' is included in socio-cultural experiences as nurses, explained 'time' as a necessary component of the "journey" through phases of acculturation and acclimatisation. Time for appreciation of the other, as suggested within Australian policies and nursing standards speaking about diversity, is what the nurses needed to meet professional standards while balancing celebration of and valuing cultural diversity as a gesture to promote acceptance of diversity. The nurses expressed the need for OQNs to fit into or achieve a level of acculturation within the Australian ways of 'seeing, thinking and doing' in relation to their practice. In the commentary on professional experiences, the nurses explained how OQNs were trying to fit into Australian nursing practice. Therefore, OQNs were actively working to acculturate and to acclimatise into the Australian society and Australian nursing practice over time.

As discussed in the personal and professional experiences, both groups of nurses recognised that time allowed them to build relationships and to support the other and to be patient and tolerant with others, therefore to improve their professional relationships by finding their own levels of confidence about the situation by developing trust and respect for each other, irrespective of differences in language and skin colour.

Throughout their interviews, nurses emphasised the importance of time, in particular the need to have time to appreciate each other by moving into another realm. By situating themselves within a novel situation, they were moving from an unknown sphere into the known sphere/field by undergoing processes of socialisation, acclimatisation and acculturation. They believed that in this way they were able to more

readily meet the personal, professional, organisational and socio-cultural expectations. Time was a central factor mentioned as a contributor to their adjustment into the new environment.

> *People need a little bit of time to adapt and change - everybody regardless of where you come from and whether English is a first language or not*.
>
> Bonny: AN

> *It does take time to build up the relationships… the people recognise your ability, it's I don't know, it depends on you know, people just like you know that, for some nurses it just takes a couple of years… it's just that time matters*.
>
> Harna: KN

> *It's just time really ..//.. Absolutely…I'd say it took a year or two.*
>
> Joyce: AmN

A number of nurses clarified the importance of transition time for them along with time to support each other. However, as depicted by Bonny, the nursing culture demanded that new nurses like OQNs transition into the workplace within a short time. This attitude sometimes denied the nurses a smooth transition into their novel situation.

> *People need a little bit of time to adapt and change - everybody, regardless of where you come from and whether English is a first language or not*.
>
> Bonny: AN

Harna suggested that her perception of lack of consideration of time needed among ANs prohibited her from seeking support.

> *It takes time and* [limited time] *creates frustration between the staff members and you* [because when] *the person asks for* [support] *and other nurses are too busy* [to help you] *all the nurses are busy, they haven't got time. They*

haven't got time to talk about that kind of thing ..//.. they think I'm a nuisance.

Harna: KN

Harna explained how she progressively gained confidence working in the Australian context.

> *I was a bit intimidated* [when] *I had to start a new career in a big hospital, that was really challenging for me and it wasn't easy at all. Compared to those days I'm now comfortable because I've got experience and I'm comfortable with the work environment in Australia ..//.. It was really hard but after a couple of years, I feel* [confident]. *You become* [more] *confident every day and each year. Your knowledge and your confidence grow inside of you every day. So after two years I was very confident to look after any patient.*
>
> Harna: KN

Harna's metaphor of gaining colour over time highlights the gradual shift to becoming comfortable as she gathered the personal, professional and social skills to feel a sense of belonging and confidence to express herself and her aspirations, and to be recognised as legitimate in the space around her. The following excerpt explains the process of change within the socio-cultural dimension.

> *I selected the photo from internet because ..//.. at the side of the desert, there's a person. There's no colour in there, it's blank. Blank* [and] *white ..//.. Normally as a person you have your own colour. I used to think of myself as green or yellow. It's a really bright colour. But there's no colour when I started my nursing career in Australia ..//.. no colour inside of the person…//..You start from the blank ..//.. it means that you're going through all the* [things] *and your life here. Without it, it doesn't look like who I am* [now] *at all. You have to survive yourself ..//.. you have to make it your own colour again from the beginning. Now I have some colours instead of a blank human figure. I have*

> [re]*filled my colour more than half. With green* [laugh]. *Green makes people comfortable and everybody loves green. I want to be a nurse who has knowledge, the personality, confidence and skills but you are always humble and you're always caring other colleagues. And that's my dream.*
>
> Harna: KN

Nurses explained their satisfaction about their journeys describing these as rewarding: "It's really worth it. I never regretted my decision to come to Australia" (Harna: KN) while Kim said

> *Because you start off with challenges often language or cultural and you develop a relationship with them and I've never had an instance where it's been a bad outcome and I think it brings a lot to the patients too.*
>
> Kim: AN

As suggested by the interviewees, having time, a reasonable period of time, to appreciate the other provided them with the opportunity to get to know each other and to close the gaps in their nursing knowledge and skills within the Australian contexts of practice.

Reflection: Socio-cultural experiences

Through this study the participants and I gained insight into a range of multiple interconnecting forces that enlightened us about relations between 'self and society', ie, nurses from different cultures coming together and working in the same environment in Australia. Although I assumed that the manner in which the nurses from different cultures worked together might be closely related to the wider community and Australian culture, I did not clearly think through these processes of socialisation to see how the historical and political influences were embedded in their everyday lives. The

Australian policies clearly need to be applied to the management of diversity in the workplace and in society. The patients' contribution and their prior experience influenced nurses' experiences. While multiculturalism invited a mandated policy to manage diversity, both ANs and OQNs believed assimilation into Australian culture and nursing practice was the only way to deal with the situations they were in. I felt that the ANs had taken their views about the 'existing state of play' before the arrival of the OQNs as the usual view of their world and even showed a 'territorial stance' to guard and preserve their view of the Australian culture and the Australian nursing practice. From the contrary 'insider' perspective, it seemed to me that the OQNs were powerless and submissive because they were new to Australian culture and approaches to nursing practice, thus their attempts to please ANs at work.

I knew what my journey as an OQN had been like as I attempted to acclimatise, acculturate and socialise into Australian contexts. This took some time. Similar experiences were reported here. I did not fully appreciate how much time was needed for ANs and OQNs to feel confident and to experience a sense of belonging.

5.6 **CONCLUSION**

Nurses' responses to the key interview question 'How do OQNs and ANs work together?' provided examples of key issues and experiences, which were indicative of a shared 'struggle', shared commitment to patient care, and a recognition of the time needed to acculturate and acclimatise to situations demanding collaboration. Interview data and their images provided data for comparison with the document analysis: Comparison of reports on actual experience against a robust set of expectations showed common intentions for optimal professional nursing practices. Interviewees' reports of their experiences of 'working together' with nurses from different cultures

sometimes conveyed a sense of shifting power relationships. The desire to manage issues and situations was sometimes conveyed as a sense of a need to control 'the other' often interpreted by nurses as disrespect and distrust of others. There was minimal reference by interviewees to frameworks existing in policies and guidelines, to guide resolutions to challenges experienced. There were aspirations for alternative approaches to cultural safety and optimal patient care.

By assuming an interpretive and critical stance on the interview data the researcher enhanced her ability to question what was happening but also to recognise the socio-culturally situated and historical characteristics to challenge the "truth" in the individuals' reports on their experiences of working with 'the other'. Hence, this appraisal of the interviews also led the researcher to reflect on and to examine her own bi-cultural experiences, and to interrogate the participants' chosen actions, but also to expand her own horizons for choice in responses to difference and widen her own and others' capacity to see, hear, and feel what the 'other person' was seeing, hearing and feeling.

The analysis of the interviews attempts to illuminate the concealed and overt meanings of everyday life in a busy health service environment, then to use these as a catalyst for change by the researcher at a social and political level, given her role as an advocate for nurses within the organisation in which the study was located.

As noted above, OQNs and ANs encountered a number of differences about expectations of behaviours and attitudes consistent with those of nursing at personal, professional, organisational and socio-cultural levels. These experiences were reported as either 'enabling' or 'limiting' factors, highlighting

i) The inconsistencies between the experiences of nurses and the expectations outlined within formal Policies, Codes of Ethics and Conduct, Standards for Practice: Professional Boundaries and Decision-Making

Frameworks that inform professional judgments. These often impacted negatively on their experiences of working together.

ii) The demonstration of positive examples of resolutions that contributed not only to optimal patient outcomes but also progressing the journeys of nurses from the initial stage of 'struggling' and feeling 'challenged' to the stages of 'celebrating' and 'thriving' through to 'collaborative interactions' indicative of a high level of acculturation and acclimatisation and socialisation to the Australian context and culture.

The illustration of a growing understanding of the 'world of work in Australia' and the challenges and difficulties for all nurses, irrespective of country of origin have been presented and reflect personal change and growth as they moved through processes of socialisation, acclimatisation and acculturation within the Australian contexts of practice.

The findings on the experiences of the nurses represent different personal, professional, organisational and socio-cultural dimensions within the study context of practice. The participants came to the realisation that achieving safety and quality in patient care depends on collegial relationships that require the resolution of power differentials, acceptance of cultural differences, and managing dissonance in the workplace through a more collaborative and open kind of engagement. This was a necessary element if they were to empower each other to learn more about the 'other'.

In Chapter 6 Discussion and Conclusions, an interpretation of the study findings, with consideration of implications for policy and practice and suggestions for future research are presented.

Chapter 6 DISCUSSION AND CONCLUSION

6.1 INTRODUCTION

Employing Interpretive Description and Critical Social Theory, this study investigated how OQNs and ANs work together in the Australian context. The study was guided by the questions: What is the nature of the context and experiences of OQNs and ANs of working together in regional hospitals in Australia? and What support strategies are available to nurses in their working environment that promote a culture of reciprocity and collaborative working relationships? The researcher also examined codes and policies that reflect the expectations of professional and organisational bodies and the ways in which they inform how nurses negotiate cultural difference in their workplace.

Coming together as co-workers in the Australian context sometimes was found to be challenging for all parties. Diversity, as a common feature of the nursing workforce has yet to be acknowledged as normal, particularly in regional Australian contexts of health services. As such, there are issues that have been highlighted in other studies that remain as concerns and barriers to effectively working together for the nurses in this study. Without a systematic and committed approach to helping nurses deal with and make the most of diversity, nurses will continue to experience dissonance, power differentials and distress.

6.2 EXPERIENCE OF NURSES FROM DIFFERENT CULTURES WORKING TOGETHER

The nurses in the study described their experiences as both challenging and rewarding. Both groups underestimated the amount of effort they needed to make in order to achieve a situation in which they could work together effectively. Their experiences were constructed according to their cultural understandings of themselves

as nurses expressed through culturally ascribed attributes, in the context of Australian professional and organisational expectations. Although both OQNs and ANs had satisfied requirements for registration in Australia, they had varying habitual ways of conducting their practice. Hence, they sometimes had difficulty in 'coming together' and establishing the kind of relationships that would enable satisfactory 'working together' The challenges that OQNs faced in this study were similar to those described in the existing the literature (Konno, 2006; Xu, 2007). While descriptions of the experiences of host nurses in Australia and in other countries are largely absent in the literature, this study revealed that ANs also faced challenges working collaboratively with OQNs.

Previous literature focused on differences, not similarities. This focus led them to experience challenges such as a need to transition into the new nursing practice and new culture and a number of challenges (Gerrish & Griffith, 2004; Likupe et al., 2014; Newton et al., 2012; Nichols & Campbell, 2010; Smith et al., 2007). However, this study identifies that both ANs and OQNs share a lot in their experiences and that without focusing on similarities, there is no platform for engagement and collaboration among nurses. In addition, this study suggests that the care that nurses provide is better when they care for each other.

Their experiences were characterised by the need to reconcile the tensions between their shared goal of providing good nursing care and their ability to negotiate differences and meet the expectations of being a professional nurse in Australia. Together, they shared the challenge of having to deal with professional and cognitive dissonance and having to realign their personal and professional identity as a both a nurse and nursing colleague.

6.2.1 Professional dissonance

Professional dissonance was evident in the experiences of the nurses even though they were clearly committed to sound professional conduct. As discussed earlier, reports on the working experiences and working relationships for the OQNs and the ANs in this study suggested a strong commitment to work together to provide good nursing care to patients. There was an acknowledgment that they needed to work together to achieve this goal. Indeed, they referred to the need for teamwork, supporting others, and collaboration. This was evident in the interviews, particularly where RNs acknowledged that they shared goals, valued partnerships, and recognised their 'interdependence'. This self-reports of the need to build effective professional collaborations demonstrated agreement with previous studies (Joel, 2013; Rose, 2011). There was a great deal of evidence that all participants were committed to patient care and somewhat open minded in a manner consistent with NSW Health CORE values and other professional codes.

However, a number of inconsistencies between the nurses' expectations and actual experiences were identified, particularly in relation to their understanding of their place and role in a diverse workforce. This professional dissonance was evident in that there was a mismatch between the nurses' attitudes and actions and the expectations outlined within documents guiding Australian professional nursing practice. While the nurses described cultural and linguistic diversity as a feature of Australian society and hence the Australian nursing workforce, they had not expected the level of diversity they encountered. They found themselves in a novel situation that they needed to negotiate in order to find a way to work together. The nurses reported loss of confidence and uncertainty associated with not knowing about their colleagues and dealing with the consequences of perceived differences and stereotypes. These experiences are inconsistent with the expectations of professional and educational

organisations that nurses should be at ease and competent with diversity in the workplace (with peers and their clientele). There is a need to accommodate an ever-challenging cultural profile within the population and workplace environment. However, they identified that at times there was a lack of behaviour demonstrative of cultural competence and cultural understanding of each other. The construction of differences was often negative rather than positive; this in turn accentuated or instigated the perception of difference.

Instances of what were seen as unsatisfactory professional conduct and examples of professional misconduct were reported. As an example, the effective professional collaboration that included mutual respect and power sharing did not exist among some of the nurses' experiences. Instead, the findings of the study report evidence of discrepancies in the perceived notions of professionalism among participants of experiences, such as behaviours indicative of bullying, discrimination and even racist undertones. These responses are inconsistent with the development and maintenance of the professional relationships among nurses that are articulated within the national nursing Competency Standards that inform assessment within all Australian educational programs that would have been part of the preparation for practice for all the nurses. They are inconsistent with the CPC, one element in particular, which explains the need to 'respect the dignity, culture, ethnicity, values and beliefs of people receiving care and treatment, and of their colleagues' and the CE which highlights the rights of nurses to be respected. They are contrary to NSW Ministry of Health's core value statement and policy that include the need for respect and the importance of a respectful workplace.

Further, the nurses explained that there was an apparent lack of accountability; no one was held accountable for the racism and discrimination, and people witnessed it with no subsequent action leading to the minimisation of such undesirable behaviours.

There was a lack of compassion towards colleagues but also minimal evidence of civility and collegiality, such as showing support for each other when someone experienced unfairness or respecting the decision that was made by other nurses. In response to some incidents, although the management of workforce diversity with affirmative action such as the application of EEO principles and counter-racism policy could contribute to the creation of a culturally competent and cohesive workforce, the nurses did not consider that these actions were sufficient to change and to achieve the policy goals. There is a lack of evidence of nurses working collaboratively to resolve these issues; hence, a sense of disempowerment ensued. Much of this disempowerment resulted from cognitive dissonance arising from feeling torn between their own situated understandings and the need to value and to trust the contribution of others.

6.2.2 Cognitive dissonance

Cognitive dissonance is an apparent psychological conflict that is raised from nurses holding two or more incompatible beliefs simultaneously (Merriam Webster dictionary, 2014). This was evident in the nurses' responses to each other such as the discussion of nursing competence and their satisfaction of being Australian nurses. The study identified inconsistencies between the espoused personal beliefs of the nurses and their actions.

The fundamental paradox for the OQNs and the ANs in this study was they were very close to each other as nurses who provide patient care, sharing many commonalities, and yet they felt distant from each other at the same time. The nurses revealed intimate moments about shared difficulties in working together in their roles as nurses. At interview, they promoted a notion of patient care that involved treating patient as whole persons, to consider their thoughts and feelings, values and to promote a positive experience while they access the health services. This ideal of person-centred

care was a big component of the nurses' work and was embedded in the nurse-patient relationship, yet there was evidence that this person-centeredness was not transferred to nurse-nurse relationships even though these were expectations outlined by the Codes of Professional Conduct and Ethics for the nursing profession. This seemed to be a paradoxical situation; the ANs and OQNs were accustomed to "being together" and working together to provide patient care but were "not together", rather disconnected and sometimes excluded. This was evidenced in how they worked separately to meet their own needs and deal with situations in which they found themselves.

Cognitive dissonance was reflected strongly in relation to views about nursing competence. It was clear that the Australian nursing profession particularly the OQN's entrance to Australian workforce was closely monitored to maintain a competent nursing workforce (Australian Health Practitioner Regualtion Agency, 2016). However, the experiences of the nurses indicated that the OQNs were scrutinised by their new Australian peers for assurance that they were competent. This ongoing scrutiny occurred despite the fact that all nurses had satisfied requirements for Australian nursing registration. While OQNs felt that they were competent in providing safe nursing care, they also felt at a loss of what to do in some instances. ANs felt that OQNs were "good" nurses but they felt unsure if OQNs were competent to provide safe nursing care. They felt responsible for the nursing care provide by OQNs. If they were in doubt about competence of a nurse they would respond by taking away OQN "in charge" opportunities or overturn care related decisions they had made. Such that, OQNs feel that they needed to continuously prove themselves to ANs in order to be accepted as competent.

There was an issue around the relationship between language proficiency and nursing competence. With a belief of "nursing is all about communication", ANs were confused

at times about the competency of OQNs' communication skills. At times, they were quizzical about how OQNs could communicate with others even if ANs considered the English language proficiency of the OQNs was not meeting their expectations such as being grammatically correct, involving a particular accent and indicative of expressions consistent with common Australian expressions. Consistent with findings reported in the previous literature (Atack et al., 2012; Newton et al., 2012; Xu, 2007), challenges in communication and language were identified as the biggest problem by the nurses in this study. However, this professional and cognitive dissonance could explain the dilemma that communication is reduced to 'language' without realising that communication is a two-way process between the sender and a receiver, thus, ignoring the basis of effective communication. This suggestion is somewhat different from the previous literature that emphasises the need for an improvement of English ability of OQNs as a strategy to deal with communication difficulties. Although there was discomfort and at times distress associated with dissonance, it provided impetus for nurses to work towards realigning their long-held beliefs about acceptable Australian professional identity and practice.

6.2.3 Realigning personal identity and professional identity

The nurses in this study demonstrated the realignment of personal and professional identity. This is different from some of earlier studies that concluded loss of self as a professional nurse in a host country. The previous studies discussed the loss of self in relation to the devaluing process and feelings of invisibility that OQNs felt in the context of the host country's nursing practice (Alexis & Vydelingum, 2004; Allen & Larsen, 2003; Deegan & Simkin, 2010). The nurses in this study experienced personal and professional uncertainty and self-doubt when they realised the full extent of their own perceptions of differences: They sometimes did not know how to think of differences and how to enact bridging of differences and thus how best to interact with each other.

Both the OQNs and the ANs were challenged by their attitudes around the 'taken for granted' aspects of their nursing practice and their cultural norms and how these influenced choices about how to interact with others at work. As discussed by previous studies (Neiterman & Bourgeault, 2015; Stankiewicz & O'Connor, 2014; Zhou et al., 2010), the nurses realigned their thinking to fit into the situation they were in. In particular, the OQNs had gone through many changes in their personal and professional identities in order to live comfortably in Australian society and to work in the Australian nursing practice context. For example, they adopted strategies in order to be seen as hard workers and valuable members of a team. The ANs regardless of their position explained that features of their roles changed from those commonly understood among their nursing peers from homogeneous backgrounds to a greater emphasis on the sub-roles of "supporter", "teacher" or even 'policing person' to maintain the safety and quality of nursing care provision. This change in emphasis in role was now not so easily attributed and limited to managers and educators whose customary roles were more aligned to "managing and supporting" as suggested in the previous literature (Dreachslin et al., 2000; Gerrish & Griffith, 2004; Timilsina Bhandari et al., 2014).

Restructuring their personal, social and professional identity was perceived as necessary by both ANs and OQNs to deal with the workplace situations they were in. This was due to a variety of reasons such as limited knowledge of each other and the other's culture and former nursing practices. The limited knowledge about elements of the differences among them led to confusion and distrust of the other. There were difficulties in building relationships and attempts to be included; the certainty of their social identity was shaken. This also influenced their sense of professional identity, especially for the OQNs, as their credibility and competence as a nurse was questioned and somewhat diminished. The nurses tried to adopt cognitive processes to adapt the new situations and environments they were in by adopting psycho-social

approaches and gaining new knowledge and skills of how to deal with each other and the situations they faced together. As they acclimatised some of the nurses discovered areas for growth in their personal and professional identity, therefore, they embraced the differences in a positive ways and started building collaborative working relationships.

6.3 BARRIERS AND FACILITATORS TO WORKING WELL TOGETHER

Barriers and facilitators to how the nurses working well together in this study related to mindsets and practices of individual nurses, the values of the nursing profession, health care organisations, and society. How the nurses work together at Australian context differs according to how they negotiate the differences, by how they resolve power differentials, by levels of commitment to engagement to overcome the “Othering” process and focusing on similarities and shared goals, and collegiality and civility as strategies to encourage harmonious working relationships.

6.3.1 Negotiating differences

The experiences of nurses in this study focus on differences in their working relationship and on achieving the provision of optimal patient care as central to their work as discussed in the previous literature (Cummins, 2009; Josipovic, 2000; Takeno, 2010; Walters, 2008; Xu et al., 2008; Zhou et al., 2011). The concept of ‘difference’ was openly and frequently discussed by both ANs and OQNs. The nurses in this study conceived differences as the divergence of cultures, ethnicity, language, communication and nursing practices, and these were seen as problematic in a climate where there is a preference for the perceived homogeneity of the past. In other words, diversity, in the main, was not seen as providing benefits, but was seen as creating tensions and challenges. In addition, the dynamic nature of difference was ignored

and not discussed in relation to the 'ever-changing' context of nursing practice; therefore reinforcing stereotypes and generalisations in relation to perceptions of one group of the other (OQNs and the ANs).

Differences, whether obvious or more 'subtle', were often assumed by nurses to be aberrant, wrong or bad, compared to normal, right or good. The OQNs feel intimidated and lack confidence in the workplace. This leads them lose trust or faith that they had previously had in themselves and their ability to be a competent nurse. They questioned the diminution of their professional and personal identity. For example, feelings of being unsure and the related low positive self-esteem were reported on by the OQNs as affecting their thoughts and actions, their feelings about others and about their work. As they were not confident, they experienced difference as a challenge and at times were fearful and unable to stand up for what they believed in. Michi, for example believed that Japanese person hygiene nursing practice was better than Australian nursing practice, but she did not ask ANs to consider adopting what she perceived as superior practice. Discussion of nursing competence among OQNs included expression of ambiguity about their competence and confidence. For example, OQNs felt they were competent in the provision nursing care for patients, but they also recognised that they did not feel confident to provide nursing care in Australian context. Not having an acute sense of self-confidence, OQNs were then afraid to take initiatives on tasks that they were able to do; they were constrained by the fear and anxiety when faced with things that they were not sure of. Consequently, OQNs initially assumed a submissive position and a belief that they needed to fit in to nursing practice and the socio-cultural norms within Australian workplaces. This finding is consistent with literature highlighting a need to adapt to the host nursing practice and an inability to transfer their own nursing knowledge and skills from their country of origin (Sherwood & Shaffer, 2014; Zizzo & Xu, 2009).

On the other hand, the attitudes to differences among ANs, rather than accepting the differences as they were, highlighted perceptions that some of OQNs were less competent when measured against usual Australian nursing practice. Nurses were concerned about safety and quality of nursing care provision. This notion was briefly mentioned in the previous literature but without much evidence for claims made (Holmes & Grech, 2015; Omeri, 2006; Riden et al., 2014; Xu et al., 2008; Zizzo & Xu, 2009). In this study, both the OQNs and the ANs were confused about OQNs' levels of competence. The OQNs felt that they able to provide safe nursing care but they realised that benchmarks for safe and quality nursing care across cultures and contexts were different. The ANs felt that initially they did not know OQNs were safe in provision of nursing care and that they were responsible for ensuring the safe nursing care provision. In practice, as explained by AN Jean, at the outset an AN decides that an OQN is not competent working as an 'In-charge nurse'. However, there were often contradictions in the AN group on judgements about OQNs' competence. The judgement sometimes came from an ill-informed knowledge base about OQNs' prior skills and experience; at other times, ANs commented on how good OQNs nursing skills were and that they were 'good nurses'.

ANs keenly felt the responsibility for explaining and teaching OQNs about the 'idiosyncrasies' of Australian nursing practices. However, some carried this responsibility with annoyance, while others willingly accepted this as part of their job. This may result in positioning ANs as superior in relation to nursing competence given their prior socialisation and OQNs in a subordinate position and implying a need to improve their levels of competence. These experiences and tensions existed in spite of the many guidelines, policies, and regulations that were readily available to provide definition and context to expectations and intentions of nursing practice in relation to the differences they faced. However, the meaning attached to the concept of difference by nurses suggested culture was a core difference that would affect their working life;

difference was ‘a small thing’ to overcome to enhance their working relationship and realignment of their personal and professional identity as they worked out the differences.

The nurses identify how differences are socially and culturally constructed within their own context, but how they need to have a better appreciation of these differences on their work across cultures within the Australian context. The nurses should not accept that these differences could lead to scapegoating and denigration. They denied those were different from the defining characteristics of the professional. There was a ‘sameness’ in being Australian registered nurses whose goals are to provide care to the patients, to maintain their dignity and self-worth, and to be respected and be supported as the OQNs and ANs progressively working more closely together in the Australian context. The experience of difference is impacted profoundly by ideology and the presence or absence of socio-cultural capital that influences power in the experiences of nurses.

6.3.2 Power and influences

In line with critical theorists’ discussion about the relationships between differences and power, the findings of this study suggest differences are played out in power differentials within the experiences of the nurses. Their differences within this diverse group diminished the ‘Milieu of familiarity’ for the nurses; they believed that homogeneity was good as they could predict and anticipate actions and messages and not be categorised as ANs and OQNs. Both groups of nurses felt disempowered at times, consequently, feeling ‘powerless’ as they are uncertain and unsure of themselves given their lack of competence in dealing with the differences. However, this powerless is soon transferred to power differentials between two groups of nurses on the nature of nurses’ working relationships. This power imbalance means that ANs are being the dominant group and OQNs are being subordinate in their workplace.

This could be explained that the power that played on the OQNs and the ANs are culturally and symbolically created within the Australian context, and are constantly re-legitimised through interplay of the OQNs and the ANs, Australian health care environment and the Australian society. To explain, I use a couple of concepts that Bourdieu uses to explain power: socio cultural capital, habitus, and fields,

Power differentials could be occurring through so called “Habitus or socialised norms and tendencies” (Bourdieu & Passeron, 1990), that guided the behaviour and thinking of the OQNs and the ANs. Habitus as defined ‘the way society becomes deposited in persons in the form of lasting dispositions, or trained capacities and structured propensities to think, feel and act in determinant ways, which then guide them’, the individual nurses were influenced by their perceptions and actions at the workplace. The Australian nursing workplace and the Australian society were fields that influenced and embedded on how the OQNs and the ANs work. While the ANs sought to preserve the status quo as nurses who hold knowledge and skills of Australian nursing practice, the OQNs tried to gain that socio-cultural capital to ensure acceptance by the ANs.

Their nursing practice is the product of an encounter between a habitus, a field that is, to varying degrees, not compatible or congruent with one another due to socio-cultural capital. Individual nurses did not know how to act and literally would be lost for words and actions. One example is the linguistic expression of nurses that the forms of practice can be understood as the product of the relation between a linguistic habitus and a linguistic market that is among nurses and patients. The OQNs and the ANs have certain habitués embedded in them, differences such as different language use, accent, intonations and the ways of speaking and communicating is a manifestation of the socially constructed characters of habitus (Bourdieu & Passeron, 1990). In a given linguistic market where Australian English is more valued, new speakers need to know how to produce expressions that are highly valued in the workplace. The nurses often

discuss English language as a form of capital that advantages or disadvantages them. Although some of OQNs came from the UK and the USA, and other OQNs had been in Australia for quite some time, language, especially English language ability is used to differentiate the power among them. OQNs from NESBs need to demonstrate their English language ability for registration as a nurse in Australia and to acquire and maintain employment, hence impacted on the economic status of nurses. In this study, English language ability was also important for accessing social networks in the Australian nursing environment. Given the English language difficulties some OQNs attributed to themselves, there were difficulties in joining in conversations with other nurses and expressing their emotions and feelings. The ability of English language skills in particular of OQNs was often blamed for many challenges the OQNs and ANs have experienced.

On the other hand, the OQNs stated that they could communicate with others well and some of ANs also thought that they were able to communicate with OQNs well. This confusion in perceptions could be explained by the work of Chomsky (1986) who suggested that communication, language and linguistic exchange were different from language competency (person's knowledge of language) but they were about use of language (language performance). Bourdieu (1991) also highlights the importance of practical competency in language and the social aspect of use of language. These explanations may lead to conclusions that the language and communication difficulties arose because of beliefs that the OQNs do not have an entitlement to speak, the ANs do not listen and the OQNs have fears of making mistakes while talking. The ANs had authority to let OQNs speak up, but sometimes removed that right by asking another nurse (an AN) to speak, particularly in their clinical handover. Therefore, their ability with language and communication may not be the sole issue but rather it might also be about attitudes and understanding of the underpinnings of achievement of language and practice competence.

The experience of nurses is influenced by other cultural capital along with social knowledge of the nurses (ie socio-cultural capital). Socio-cultural capital influenced the tensions within interactions that arose among ANs and OQNs, sometimes with subsequent actions presenting as power differentials. Thus, this influenced how they worked together in the contexts of Australian nursing practice. The situations in which they 'came together' in an Australian workplace encouraged an evocation of a dependence on nurse's socio-cultural capital, that is, the knowledge and skills on the profession of nursing, the new culture, and the sometimes more substantive and overt professional and organisational rules and regulations. This socio-cultural capital informed pedagogical decisions about if and how they shared learning in their workplaces. Their new socio-cultural lenses reduce the social complexity and diversity of working to that of individual work performance. It is clear that the more a nurse holds socio-cultural capital, especially reflected in those who are deemed to have knowledge and skills of Australian nursing practices and culture, the better they are accepted and empowered in the workplace. The nurses who do not have optimal language skills and hold onto different knowledge about nursing practice and culture are more likely to experience inequality and be marginalised. This situation is exacerbated by their lack of competence to deal with diversity.

Therefore, the power relativities between an OQN and an AN were significant, particularly the OQNs with limited knowledge and skills about and/ or deviating from the usual Australian nursing practices and culture. For the OQNs, significant vulnerability and powerlessness arose from being new to the Australian context of practice and the need to assimilate. This was exacerbated by AN's attitudes towards them such as distrust, disrespect, and bullying and discrimination. Therefore, for some time, they belonged to a marginalised group in the Australian nursing workforce and society or experienced an unfamiliar loss of self-confidence and autonomy.

On the other hand, the ANs with greater levels of prior knowledge and skills of Australian nursing practices, contexts of practice and culture, positioned themselves as superior compared to the OQNs as comparatively inferior. This led to movement away from a peer relationship to one where 'teachers with the knowledge' (the ANs) behaved as such to their students (the OQNs); this subsequently affected working relationships. Many nurses dealing with diversity and competence may have limited use of critical thinking to judge their ability to identify that the differences were due to the different context and situations they faced and could be dealt with by acquiring the nursing competence that was required by their profession. The CPC or CE both indicate how to deal with diversity, but the need for this learning needs to explicated and an appropriate learning event constructed in response. Instead, this vulnerability at different times created a power differential in the relationship between the two groups of nurses while working together when this 'professional development need' was not recognised and managed. This failure to identify the issues openly and with all parties involved contributed to the further power differential between the OQNs and the ANs. As discussed in the literature (Hunt, 2007), 'one way' assimilation is one example of perpetuation of the power differential that was experienced by the nurses in the present study. This one-way assimilation is widely evident in the recruitment of OQNs in the host countries worldwide for example the requirement for OQNs from certain countries to complete transition programs. This strategy aims to enhance the standardisation of nursing practice and risk management in the host country's nursing practice. However, if not well understood or managed well, this may not help the relationship or experiences of the nurses (both OQNs and local nurses) as acclimatisation and acculturation are required by the both groups of nurses by employing two-way learnings.

The findings of the study indicate that the ANs were in a dominant group and tried to maintain the status quo in the workplace. The ANs were very strong at the latter, even

when the presence of the OQNs in their workforce changed the dynamics and the characteristics of the work environment. In addition, the interviews of the ANs portrayed an image of all Australian nursing practices as 'the right ones'. Many excerpts of the interviews praised the OQNs if they were deemed to have 'fitted' into Australian nursing practice. In particular, the choice of expression of Kim when she said 'she fitted in' implied the pre-eminence of the Australian nursing practice context.

Both groups of nurses saw their situations involving a sense of disequilibrium as 'taken for granted' and often do not question the status quo. This was evident in that the nurses' acceptance of their positions as the OQNs who are 'new' to the Australian society and nursing practice, therefore they are the ones to 'learn' or 'fit' into the new nursing practice and culture. The ANs also exhibit firm beliefs that they are the ones who know the Australian nursing practice and culture, therefore, they need to 'support; or 'teach' the newcomers. This is acceptable regardless of the newcomers identifying their own learning needs. Great care is warranted when expressing doubts about the competency of OQNs as professional nurses or when discriminatory actions towards the OQNs become the norm.

All nurses struggled to find a point where each could have been satisfied that they had closed the gaps among their power differentials; the nurses required opportunities to facilitate effective socialisation, acclimatisation and acculturation into the workforce environment. However, the nurses often dealt with this in one-way assimilation process rather than employing a bi-directional learning process. For example, on recognition of differences in nursing practice, the OQNs thought that they needed to adopt entirely the elements of Australian nursing practice and culture. They defined themselves as on the 'wrong end' of the continuum of acceptable practice and therefore needed to change. There was no evidence of their critical thinking about the patient/client situations at hand and the currency of evidence as a basis for practice. The ANs also

uncritically requested OQNs' conformity with Australian ways. This included ways to interact and communicate, and compliance with the working environments such as observing rules, familiarity with clinical environments, and adaptation to the environment. There was with an acknowledgement by all nurses that this was in the best interest of patient care. However, this adaptation process also led them to 'struggles' as the OQNs needed to assume greater levels of responsibility for adaptation to survive and the ANs needed to make sure that the OQNs provided nursing care in a way that was consistent with Australian policy on practice. The ANs felt that they needed to safeguard standards of care provision and Australian nursing was the best and most familiar approach. An inherent tension sometimes existed in the relationships between the OQNs and the ANs during their engagement in the provision of care. This tension and imbalance could further be explained by the concept of 'Othering".

6.3.3 The "Othering" process

In the context of diversity, tensions were created by the differences through adoption of what could be labelled the 'Othering process'. This concept was presented in the literature as marginalisation (Magnusdottir, 2005; Omeri & Atkins, 2002; Xu, 2007) or disengagement (Konno, 2006; Newton et al., 2012; Omeri & Atkins, 2002; Xu, 2007; Zhou et al., 2011). In their journeys of working together, the nurses' challenging and positive experiences led to them, to either work alone or along with other nurses to meet their responsibility as nurses. Although the nurses originated from different ethnicities, with different coloured skin and different racial characteristics, nurses did not distinguish themselves by these characteristics of difference, but referred to them either as ANs or OQNs. The concept of 'Othering' explained a mechanism for dividing two different groups such as the OQNs and the ANs as "us and them". This 'Othering' process is known as a symbolic cultural code for distinction between human

categories; it forms the basis of ways of maintaining social order (Krumer-Navo & Sidi, 2012). Krumer-Navo and Sidi (2012) state that “We”, the self is perceived as possessing good and positive qualities, while “they”, the others are the owners of negative qualities. In this study, the ANs were portrayed as the ones who held privileged dominant positions in the host’s context of nursing practices, culture, language and social emotions. In contrast, OQNs were portrayed as the other or holding more marginalised positions. This could be because that fact that the nurses concern for language and communication ability, behaviours and interactions, and relationships within the context of Australian health care system. Therefore, it is more likely they employ the ‘othering’ process to deal with their discomfort in this the context. It could be that the researcher was the one who contributed this ‘othering’ process by asking them the questions such as ‘How do you work with ANs or OQNs?’ Regardless, the ‘othering’ occurred as both the OQNs and the ANs ignored the similarities or commonalities that they shared or the benefits of having different prior experiences but placed emphasis on the differences, suggesting that these were contributing to problems. In other words, although both the OQNs and the ANs shared many similarities such as a shared value of their work as a registered nurse, provision of nursing care to their patients, and the influences of their work environment, systems, cultures, they focused on the differences. This negatively contributed to their experiences, causing challenges and difficulties in their working relationships and experiences. The ‘Othering process’ was an underlying mindset (Calhoun, 1995), 1995); nurses employed the process that in turn impacted on the experiences both OQNs and ANs working in an Australian context.

Their construction of differentness with the Othering process (‘us and them’) caused a power imbalance between the two groups of nurses reinforcing and reproducing positions of domination and subordination between them. It was about senses of ‘self’ and ‘the other’. In this study, according to the nurses’ reports, the self and the other

was reflected in different levels, contexts and ways; ANs versus OQNs, Australian versus overseas nursing practices, Australian culture versus other cultural elements, and existing versus new staff. For example, for the OQN, the self was the OQN and their personal identity and culture, nursing practices they have learnt and practised, the culture they expressed in their countries of origin and being a new staff member. The "others" were the ANs and their central tenets and values. For the ANs, the self was quintessentially an Australian nurse, Australian nursing practices, and culture and the existing, sometimes longstanding staff members. The others were the OQNs.

All respondents expressed experiences of OQNs as the ‘rites of passage’ as they unlearned their original roles in another context of practice and prepared themselves for new contexts, scopes of practice and roles and functions. As discussed in the review of literature in Chapter 2, a need to adopt new nursing practices by OQNs was emphasised strongly and the OQNs assumed an active learning role. However, the ANs also recognised the need to transition into the new work situation; they progressively changed to meet the new work situation. The participants identify collegiality and civility as the keys to this process.

6.3.4 Collegiality and civility

Collegiality and civility are both front of minds for nurses when the nurses working together. Instead of the previous literatures’ emphasis on strategies such as transitional programs, cross cultural awareness training, and English courses (Deegan & Simkin, 2010; Konno, 2006; Takeno, 2010; Xu et al., 2008; Xu & Zhang, 2005; Zizzo & Xu, 2009), the present study indicates that each action, each word they spoke, and each thought impacted on the manner of working together. Individual well-being and quality of their relationships at work were greatly important in their nursing work and in the provision of quality of patient care. Their attitudes towards challenges while working together were perceived as a ‘little thing’, a ‘little problem’ and causing ‘a little

confusion'. They thought they could address these challenges by employing collegiality towards colleagues and displaying civility as human being. For example, they believed that knowing how to call upon a person in the right way or explaining the nurses' rights in Australian enhanced their working relationship and experiences. Similar strategies to those identified in previous literature were found; demonstrating acceptance, respect for 'the other', showing a sense of helpfulness and support for each other (Konno, 2008; Smith et al., 2007). Previous literature encouraged local nurses to attend cross cultural awareness training or apply systematic governance like Zero Tolerance and elements of the *Racial Discrimination Act* 1977 might to assist in minimising racism and discrimination. However, this study emphasised that learnings from each other within the culturally safe environment enhances the likelihood of reciprocity through positive communication and better protection of the rights of others. These are not all special attitudes or actions, but part of everyday life that any human being needs to follow in society. This is a reason that participants believed that these 'little things' or collegiality and civility could make 'big' differences in the extent to which they successfully worked together. This is the case with communication and language difficulties. While OQNs are often asked to improve their English skills to enhance the communication in the past studies (Kawi & Xu, 2009; Konno, 2006; Xu & He, 2012), nurses in this study asked for professional communication that emphasises active listening and being effective in communication.

Collegiality and civility were discussed as facilitators of their working together well, but the nurses showed lack of insight about the extent to which they themselves become a powerful influence over what kind of difference they could make in the care decisions and in improving working relationships, hence improving the quality of care. For instance, the findings of the study suggested that if the nurses were tolerant about the 'little issues' or if individuals knew how to deal with little things, the differences could be addressed in a positive way thus also improving their experiences of 'working together'.

As suggested by Alexis et al. (2007), valuing other colleagues is fundamental for effective teamwork and patient care. However, the nurses fail to see that no matter how different one might seem to be, the reality is that the OQNs and the ANs all shared the common bond of humanity and being a RN aspiring to achieve optimal patient care. They did not recognise that their emotions and working experiences tied them together and they often have far more in common with one another than they originally have thought.

The study identifies support from managers and educators within the health care organisations as one of organisational factors to enhance the nurses' working together. However, it is a matter of style in management; it is not about the need to 'manage' them as indicated in the literature (Sherman & Eggenberger, 2008). It is about the manager's ability to support a diverse workforce in their everyday business. The managers and educators need to support the nurses when they are challenged by differences and situations. Their sense of safety, of self and professional identity is paramount. Behaviours and attitudes suggesting inclusion make positive differences to the nurse's working experiences. The managers and educators need to encourage positive behaviours and attitudes such as open honest communications, respect and trust, teamwork, cooperation and good work relationships. These behaviours and attitudes should not be indifferent to matters related to race, educational backgrounds, countries of origin, language and culture.

Further, the findings of this study suggest that simply showing tolerance may not be good enough if they are to work each other competently and harmoniously. As demonstrated in the multicultural policies and various guidelines for nurses, most nurses should approach situations with good will and a positive frame of mind, for finding common ground rather than looking for differences. This study states that the nurses needed to accept that they were co-workers who were to provide care to the

patients and they needed to each other well regardless of the differences. If one is proactive on the differences, this gives both parties comfort. As such the experiences of the nurses differed as individual nurses went through different levels of acculturation, acclimatisation and socialisation in different stages and timelines. It was clear that both OQNs and ANs become acculturated to the other through their interactions at work; working out personal, professional, organisational and socio cultural differences to some extent.

6.4 ACCULTURATION, ACCLIMATISATION AND SOCIALISATION

In the context of their work, nurses highlighted that their working together in an Australian health care system was a journey of being acculturated, acclimatised and socialised. The acknowledgement of these processes among OQNs was emphasised by other studies (Alexis et al., 2007; Deegan, 2007; Dreachslin et al., 2000; O'Brien & Ackroyd, 2012; Seo, Kim, Lee, Park, & Yoon, 2013; Zhou et al., 2010). This study's findings lead to claims that those processes are required for both OQNs and ANs and they are complex and dynamic. In the beginning, they find working together as a series of novel situations and they experience levels of uncertainty and loss of confidence. As described in Chapter Five, for many reasons the OQNs and ANs felt that they were strangers to each other when they first met. Although some of them were aware of some other cultures due to past personal exposure to them, knowledge about and understanding of each other were limited. There was no single homogeneous group of either ANs or OQNs. Not even all those who spoke English as their native language shared the same cultural heritage. Rather they were all individuals sharing certain aspects of culture. While working together they learn about each other's culture, professional and organisational culture. This acculturation, acclimatisation and

socialisation process differed for individual nurses and by the contexts in which they are situated.

The experience of the OQNs and the ANs in these acculturation, acculturation and socialisation processes were the results of ‘trial and error” and included some experiences of domination or cooperation along their journeys. The nurses, OQNs or ANs, described their working journey as often being difficult, challenging, and as requiring many ‘trial and error’ processes for them to develop as a member of a harmonious team. This team membership occurred through exposure to new and sometimes complex situations that, at times, challenged previously accepted and taken-for-granted professional boundaries within the nurses’ working relationships within the Australian nursing profession. Both the ANs and OQNs used the domination approach for adaptation to Australian nursing practices and the ways of interacting and communicating with each other. The OQNs were intentionally learning and adapting to the dominant nursing and Australian culture as a sub-dominant group, while the ANs, a dominant group were less obviously actively learning about the cultures of the OQNs as they felt that the OQNs the ones who needed to adopt elements of Australian culture. Despite this, their working relationship was based on a cooperative approach. Although the attitudes for learning about the other cultures differed between the OQNs and the ANs, they cooperated in an effort to meet their roles and responsibilities as registered nurses. They perceived that a cooperative intercultural approach was beneficial to raise awareness and understanding about each other to promote their working relationships. For example, while expectations about culture impacted on their experiences in many ways, they needed to realise that appropriate intercultural interactions between them relied on non-static and contextualised cultural views and ‘knowing the other’ improved their intercultural interaction. However they needed to have a better acknowledgement that culture unfolded dynamically in practice and was socially situated in specific contexts like the situations they were in; in the initial stages

of ‘working together’ there were neither open conversations between the OQNs and ANs about expectations of the other nor guided by formal policies and Codes of Conduct and Ethics.

Ultimately, over time, the ‘trial and error’, ‘domination’ and ‘cooperation’ approaches helped them to build a hybrid culture. Initially, the nurses in the study seemed to hold on to their own expectations about culture and accepted the Australian culture as an acceptable one, thus placing the blame for challenges within patterns of migration of nurses.

They had a limited understanding that culture was changeable and was in a constant state of flux in many, but sometimes imprecise ways and was constructed through social conditions together with the nurses’ responses to them. Therefore, it needed to be viewed within the larger context of history, professional and Australian society. This hybrid culture was specific to these OQNs and ANs while working together. As Suggested by (Bardhan, 2011; Casmire, 1993), this hybrid culture built by the nurses made them engage in an active and coordinated, mutually beneficial process of building a relationship to work together. As explained earlier, the existence of the OQNs and the ANs together in the Australian health care system may not be avoidable in a foreseen future given the global movement of labour and the current Australian Nursing workforce situation of shortages. The ability to build cultures within cultures and communicate effectively at a workplace is essential to develop collaborative relationships and to achieve optimal nursing care provision for a diverse Australian population. This is achieved by involvement in acculturation, acclimatisation and socialisation processes that are part of the journey that individual nurses take.

As Featherstone (2000) suggests, the world has come to be seen as a locality or a singular place with elements of common humanity; this perspective ‘is nothing if not limited and contested, but it does point to the localisation of globality, the perception of

the finite and limited nature of the world" (p. 92). He goes on to say that. a local culture can be perceived as being a particularity that is the opposite of the global. The emphasis is placed on the "taken-for-granted, habitual and repetitive nature of the everyday culture". When direct face-to face contact occurs between people of different cultures, certain circumstances (such as formal Codes and Guidelines informing professional practice in Australia) reinforce local identity. When nurses from different cultures come together, there is a need to make these formal guidelines and codes of professional practice "practically intelligible"; they need to underpin processes of socialisation, acclimatisation and acculturation.

The nurses achieved different levels of acculturation, acclimatisation and socialisation as newcomers or the known to the Australian context, or as they moved around within that context, they were constantly facing the consequences of what they did, how they did it and how they interacted while working in the hybrid culture that they have developed. The development and maintenance of personal, professional and organisational cultural elements were meant to ensure the safety and quality of care within a respectful and inclusive environment. Acculturation, acclimatisation and socialisation of individual nurses into the workplace and the dynamics of cultural change in the healthcare setting are equally important when they work together well. Thus, this study calls for clear acclimatisation, acculturation and socialisation processes for nurses of different cultures in the future. The inherent tensions between the rapidly developing diversity at work and new and emerging socio-cultural developments in the wider society should be discussed among in their personal and socio-cultural experiences in relation to factors and conditions that influenced the nurses' responsiveness, or otherwise, to these changes.

Given that the parameters of professional nursing practice were the same for all nurses, when presented with a need to realign their personal and professional

identities within a new workplace culture and environment, it was ‘they’ who constructed their own perceptions of ‘differences’; they themselves created a level of dissonance, they embedded power differentials during the process of acculturation and acclimatisation to work together. While these findings are reported in the literature, but in a limited way, this may warrant further investigation in future studies. However, the following statements may be raised based on the findings of study of nurses from culturally and linguistically diverse backgrounds working in a health practice context: Recognition of needs of acculturalisation, socialisation and acclimatisation among nurses is needed;

- Coming together demands acknowledgement of, acceptance of and respect of each other
- Working out ways of dealing with each other suggests a need for respect and openness to negotiate the differences and resolve power differentials
- Working together in an ongoing relationship suggests a need for collaborative engagement to enhance experiences around a professional approach to patient care by managing professional and cognitive dissonance.

At the conclusion of the study, it would seem that those assumptions developed at the commencement of the research are upheld; the existing policies and protocols on cultural safety and competence have not been well implemented in HNE Health. Better management of socialisation and acclimatisation of OQNs and ANs is necessary and more work needs to be done on exploring the mindsets of different people from different cultures while working in health services.

Central to the findings was the extent to which there was minimal acknowledgement of the direction and guidance provided with the Competency Standards for Nurses in Australia and Codes of Professional Conduct and Ethics that were intended to

underpin and impact on the behaviours of all the nurses reporting on their professional experiences. The self-reports on cross-cultural experiences highlighted shortcomings in actual practice. The expectations of nurses of their peers sometimes highlighted situations where these competencies should have shaped both the OQNs' and the ANs' actions and behaviours with colleagues and patients, and should have provided detail on limits to scope of practise. When taken in a particular context, their capacity to accommodate diversity within their co-workers was not evident. The study identified that nurses lacked the resources (human and other) to achieve critical understanding of the potential value of cultural diversity within the workplace. Access to better direction when it was available enabled them to better analyse, appreciate and transform the circumstances that shaped them when confronted with diversity in the workplace. They needed to be able and to see more clearly how they shaped their own circumstances.

The position arrived at as a result of conducting the study suggests a need for alternative conceptual frameworks for dealing with culturally diverse workforce arising from globalisation, particularly in health services that are the recipients of the migrating nurses across countries and cultures. Therefore a conceptual framework for the management of these processes within the workplace is required, one that limits the organisational culture of blame and reinforces the broader culture of successful acculturation to the Australian context of nursing practice. Figure 5 demonstrates stages of socialisation and acclimatisation that those nurses progressed through, as they become more deeply aware of and fully appreciated the expectations of professional nursing in Australia. The achievement and maintenance of safety and quality in patient care depends on collegial relationships; there is a need to appreciate differences, resolve power differentials, and manage dissonance in the workplace.

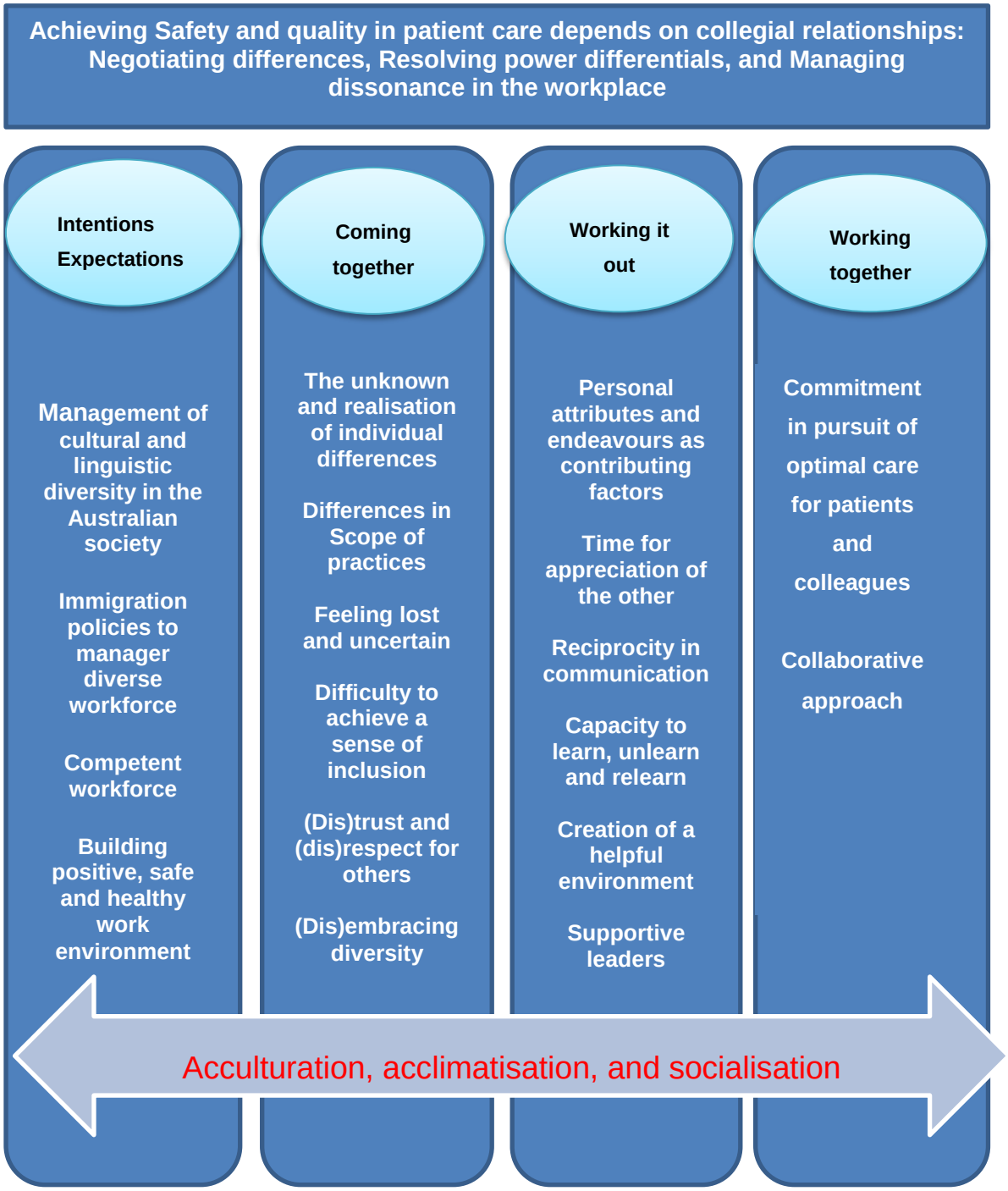


Figure 5: The experiences of OQNs and ANs working together in Australian context

6.5 **IMPLICATIONS OF THE STUDY**

This section addresses “so what’ of the study and its findings. Employing the Interpretive Descriptive approach, the researcher aimed to generate knowledge relevant for the clinical context of nursing and health care. With an acknowledgement that nursing practice environments and cultural understandings are ever changing, the key elements and critical factors that arose from this study are considered in relation to implications for future workforce planning, policy, practice and education in nursing. From this analysis, practical suggestions and recommendations emerged that may facilitate mechanisms to achieve a sustained change in practices and enhancement of the acculturation, acclimatisation and socialisation of the nurses to benefit their working relationship and their role as health care providers.

6.5.1 Implications for nursing education

There are a number of implications for nursing education. Nursing education needs to prepare nurses for active citizenship in a global workforce. This will enhance the normalisation of diversity in the nursing profession. The notion of living and learning in a globalised society may be a guiding principle that underpins the nursing education. The concept of developing a global mindset coupled with habits of mind, acknowledgement of responsibility and accountabilities of nurses should be strongly represented in all learning events within nursing education. As Sinagatullin (2006) suggested, strategies for lifelong learning cannot be effective unless they represent a concerted effort within the formal education system itself and are linked to all the other settings where education, training, and skill formation take place in practice. The focus of these strategies will be increasingly important to the workforce, whose skills need to be constantly renewed under the impact of changes in work environment. With this in mind, nurses will conscious of and possibly be able to manage the diversity and ever

changing environment as they apply and transfer their learning from universities to clinical learning and practice. The competence to manage culturally and linguistically diverse workforce will enhance nursing care provision to patients from diverse backgrounds and hence promote the concept person centred care. This then assists nurses to accept and appreciate differences they experience in a workplace, consequently encouraging acceptable professional conduct and equitable working relationships. Therefore, nursing education needs to accommodate the global nursing workforce by building the capabilities of both ANs and OQNs in dealing with cultural differences and other diversity in the following ways:

- Being better informed about behaviours that reflect the National Competency Standards for the Registered Nurse, the Code of Ethics (ICN, 2012) and the ANMAC's Code of Professional Conduct for Nurses and their contribution to assuring safe patient care and collegial working relationships;
- Aiming for greater awareness of the political, economic, socio-cultural factors that influence nursing practice;
- Ensuring alignment between the nurses' knowledge and beliefs and the expectations of the profession including working with colleagues from diverse socio-cultural backgrounds is required: Consistent validation of providing 'what's right for the patient' is needed at all levels of clinician and always;
- Pursuit of optimal communication strategies; and
- The existence of healthy levels of tolerance of the other is required given the importance of respectful and inclusive practices in an increasingly multi-cultural environment.

These strategies to prepare nurses to accept diversity as normal and to work in a diverse workforce need to be evident in clinical practice.

6.5.2 Implications for nursing practice

The findings of this study imply a need for acculturation, acclimatisation and socialisation among nurses when OQNs and ANs set out to work together in a nursing context. The OQNs and the ANs both have their own culturally derived beliefs on how to work with others. Acceptance that these beliefs can be upheld in novel situations is not a realistic expectation; it is not enough when nurses from diverse backgrounds work together. The processes of acculturation and/or acclimatisation take place in a progressive manner and require bi-directional ownership as evidenced in this study. This finding is different from those of previous studies that suggest a quick fix or one-way approach of OQNs adopting the host country's nursing practice and local culture as strategy. This study implies that the achievement of professional empowerment and the capacity for nurses to work and feel culturally safe requires collaborative engagement among nurses to minimise professional dissonance and power differentials and promote collegially and civility among nurses.

The aspect of collaborative engagement in the workplace has not been a central subject in previous studies. Use of a collaborative engagement model of practice is critical if nurses are to enhance their work experiences. Despite the existence of numerous Guidelines, Policies, and Codes that are meant to inform processes of their working together in nursing contexts, these are not used or understood appropriately and discussed openly. For all nurses, there was a belief in the need to offer the best possible care for patients (the result of shared vision, ownership of nursing purpose and direction) but the nurses (now all Australian RNs) were operating in a vacuum around mechanisms for acculturation to a novel environment and were imposing preconceptions on others about each other's fitness for practice. There was a 'gap between 'intentions' outlined within the various formal documents available and 'outcomes'- the actual experiences and behaviours reflecting inappropriate attitudes

and values. There was not a high level of ‘positive collaborative engagement’ at all times because:

- There was no direction on personal and professional orientation to ‘good interpersonal relationships across cultures,
- Nurses were not working in an ‘open culture’ but often in a ‘culture of blame’,
- There was not always a climate for ‘positive learning about the context or the experience of the other’,
- Appraisal and rewards were not accurately determined or applied,
- There was not always an expectation that all nurses, irrespective of background and country or origin, would be involved in decision-making and change processes, and
- There was not always a sense that everyone was valued and empowered.

A central premise of the interpretation of findings of how the OQNs and the ANs work together to achieve the optimal care provision required the collaborative effort of all individual nurses, all professionals and personnel within the organisation and wider community. It also points to the idea that change is necessary within the organisation if staff members are able to support them to acculturate and to acclimatise to novel situations to provide optional levels of collaboration within their working relationships. Inherent in this interpretation of their situation is a call for assistance in building confidence and competence around ways to deal with personal, professional, organisational, and socio-cultural differences and their sense of dissonance in the workplace. All actions suggested, if managed well, could ensure patient safety. However, role modelling may be required to assist the nurses to identify the issues and what to do when experiencing difficulty when working within a diverse workforce.

Interpretation of this study’s findings showed that both OQNs and the ANs were not well informed about the substance of Guidelines and Codes that should have

influenced their values and behaviours. They reported facing many problems related to an apparent lack of cultural competence; mistrust of the other, disrespect for others, experiences reflective of discrimination and harassment and consistent with oppression and an imbalance of power, and a general lack of support. On the other hand, there were also reports of nurses' helpfulness and interest in others, acceptance of differences and supportive leadership that enhanced their working relationships and their performance. Thus, to overcome any challenges, a greater focus on collaborative engagement is advocated which incorporates the strengths of both the OQNs and the ANs.

The finding that nurses did not share an understanding of professional communication requirements in particular, the importance of reciprocity in communication is concerning. It is good that the nurses recognise that communication in the health care settings is critical for the provision of safe and quality health care, teamwork and collaboration. However, they lack an understanding that the success of communication implies that all parties involved in the care need to develop a "partnership" and each party is fully informed about the messages they deliver to enhance active involvement in the decision-making process and establishment of agreed upon expectations and goals. Techniques that reduce the impact of cultural nuances and promote a better communication such as ISBAR and AIDAC can help to prevent misunderstanding and guide professional communication based a standard framework. For education and support for use of such strategies would help to overcome some of the challenges associated with language and culturally ascribed communication habits and practices.

Collaborative engagement, along with more emphasis on developing cultural and linguistic competence provides a central strategy for intervention to improve processes for better socialisation, acculturation and acclimatisation of the nurses in any new working environment. Collaborative engagement activities should reinforce the need for

cultural competency, encourage acquisition of attitudes and adoption of behavioural changes by the nurses to deal with differences identified while working together. Engagement opportunities can provide a balance for the effects of socialisation, acculturation and acclimatisation within the work environments while being sensitive to the need for intentions and expectations of the nurses. Open communication across and among ANs and OQNs, professional development and use of feedback from individual nurses and subgroups needs to be a part of improvement process of collaborative engagement. Where possible, an ongoing participation by the nurses in the development of collaborative activities and programs may enhance socialisation, acculturation, and acclimatisation. This will also increase ownership, shared appreciation and understanding of each other, without which change cannot occur. Collaborative engagement opportunities encourage those informal dialogues, which could encourage other staff, nursing profession, organisations and wider community members.

There is a need to recognise that the nurses can improve care through greater collaborative engagement within and across the professions between the patients and carers in the workplace. Collaborative engagement to develop partnership and alliance models of relationships rather than to develop hierarchical structure among nurses is required to work successfully. Ongoing professional development of the existing workforce may need to focus on mechanisms to enhance inclusive behaviours towards nurses with different cultural backgrounds, different scopes of nursing practice and different communication styles. They may provide them to a culturally safe environment that minimise concerns over racism and bullying and feeling empowered to do anything, therefore accepting diversity in the workplace as a part of their working lives.

The existing peer review, coaching and mentoring should be informed by a culturally inclusive framework, which demonstrates openness and mutual respect may be the

most beneficial strategy as RNs and OQNs can provide feedback to each other about their clinical practices and facilitate professional development by developing specific skills and knowledge to attain identified goals and nurture professional growth. While there is no evidence of how reflective clinical supervision works, if incorporated into clinical supervision greater personal reflection in and about professional practices can focus support on the attainment of personal and professional goals, empowering and enabling all RNs irrespective of country of origin so that they perform well in the Australian context and further develop capacity and skills. These approaches require formal agreement between colleagues about the learning needs; initial confirmation and assessment of knowledge and skills needs to be matched to position descriptions and professional competency requitements of the RNs as well as issues of acclimatisation and acculturation. The nurses need to take active roles to assess themselves and identify their learning objectives at the outset. Both the OQNs and the ANs need to adhere to the national standards. Although time and attitudes were identified as barriers, this strategy is necessary for assurance of safe and optimal patient care. Collaborative engagement along a better preparation of nurses to work with diversity will enhance the working experiences of nurses in a global nursing environment. When strategies of nursing education and nursing practice are achieved with nurses from across cultures will be able to work together optimally to provide safe and quality patient care as demonstrated in Figure 6.

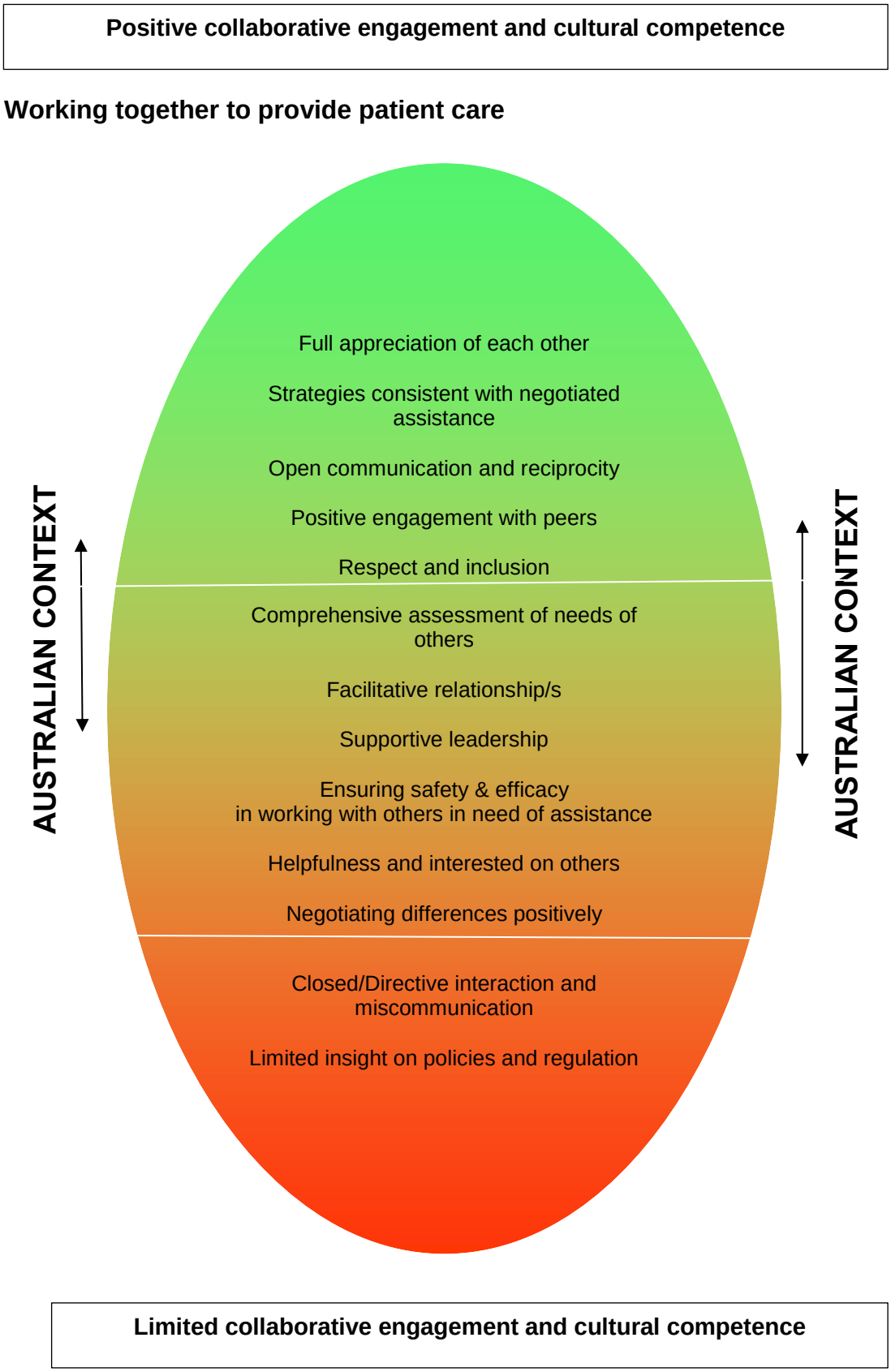


Figure 6: Collaborative Engagement Model for Nurses from Different Cultures

6.5.3 Implications for policy

As discussed above capacity building strategies in nursing education and nursing workforces would enable the nurses to be more proactive in shaping policy directions. This is significant as the ever-increasing demands of the nursing profession and nursing shortage. The Australian nursing workforces are likely to place greater pressure on nurses to work in a diverse nursing environment into the future. The study findings identify many challenges for nurses in a diverse work culture. This would suggest that future policy development based on proactive actions to prepare nursing workforce, needs to be designed or enacted to optimise the abilities of nurses to be culturally and linguistically competent and to provide an environment that promotes cultural safety among nurses. This would inform management strategies for the ever-increasing demands on this professional group.

Being at the interface of public policy initiatives around nurse migration linked to work, OQNs and ANs are in a unique position to inform policy makers about what works well and what hinders working relationships. As noted above the nurses' ability to engage with each other and build on workplace relationships is pivotal to policy success. Without scrutiny of how well policy impacts actual practice, both ANs and OQNs may be exposed to situations that cause them to feel vulnerable. Appropriate and timely interventions arising from evidence-based policy are required to secure positive workplace cultures and optimal patient care. The extent to which this is appreciated by professional and health care organisations responsible for analysing data and developing policy has not been identified in this study. However, the findings do suggest that there is a limited procedure to deal with the consequences of professional dissonance and to develop harmonious working relationships among nurses from different countries of origin. Therefore, future policy development in this area may be enhanced by:

- participation by ANs and OQNs in structured learning events that allow them to realise the alignment between sound evidence and national and state based policy on workplace developments around optimal outcomes for their clientele and peers,
- analysis of workforce capacity to meet demands on the diverse nursing workforce, and
- recognition of the need for investment in support strategies for nurses from diverse backgrounds.

6.5.4 Implications for research

In this study, the OQNs and the ANs resort to reliance on wide-ranging prior experiences with an intention to provide optimal patient care. However, their experiences represent a range of professional and organisational expectations and in some instances professional dissonance, power differentials and accommodation of differences in their daily practices. These findings conflict with the intentions outlined within professional standards, regulations and guidelines of the Australian nursing profession and the Australian society. Therefore, clear action to resolve these conflicts is required. However, these findings do suggest that there is scope for the development of a theoretical framework that reflects the diverse range of issues and accommodate the dynamic care environment that OQNs and ANs confront in practice. Future research examining the elements of facilitative practice as a basis for patient centred care may inform part of this theoretical framework.

Along the continuum of responses, some OQNs and ANs have been challenged by minimal facilitation of strategies to prepare them to work together and by a need to be acculturated, acclimatised and socialised for them to work together for optimal patient care. The findings suggest that the existing policies and guidelines have not been fully

utilised in their workplaces by most nurse and possibly their nursing managers. In a diverse work environment context, future research analysing leadership roles and functions as well as attributes of leaders is warranted. This body of work may help to identify how self-efficacy and reduced dependence on direction can be facilitated in OQNs and ANs to ensure greater responsiveness to ongoing and inevitable change in the composition of the workforce.

Guided by the research question, this study focused on the experiences of OQNs and ANs while working together at a time when more OQNs have been entering the Australian nursing workforce. However, future research is needed to ascertain the needs and perceptions of patients and other health professionals within the health service, with respect to dealing with diversity among peers and their clientele. In addition, evaluation studies monitoring the longitudinal outcomes could identify perceptions of the extent of those nurses' experiences of acculturation, acclimatisation and socialisation have had on their working relationships. In summary, further research may be undertaken to:

- examine strategies to enhance 'connectedness and inclusion' within workforce,
- identify strategies for enhancing working relationships and cross cultural communication, trust and mutual respect, and
- critically analyse the role of leaders in supporting the OQNs and ANs.

6.6 **LIMITATIONS OF THE STUDY**

This study was undertaken to provide rich evidence about the phenomenon of workplace diversity, but not to generalise the findings. Although the numbers of nurses in the study is small, ideas and concepts arising from this study will inform theoretical

perspectives that can be viewed in relation to other studies. However, the focus of the study on the experiences of OQNs and ANs meant that there was no inclusion of patients and other health care providers. The nurses' hesitation to speak about certain aspects of their experiences limits the findings of the study and undertaking single interviews does not allow for understanding of experience over time. A longitudinal study may lead to better appreciation of processes of relationship building and cultural change. The use of images was meant to enhance the expression of experience, but only three nurses presented images during the interviews. However, study findings have been enriched by those images to some extent, but may have been more so if all nurses had brought along artefacts to the interview.

The findings of this study derive from the Australian context. It is important to consider the historical, political and socio-cultural context of Australia. The nurses in this study commenced their work in the early stage of emergence of a more culturally and linguistically diverse workforce at the local health district where the study was conducted. Since the inception of this study, there has been an influx of OQNs at the Local Health District. As a nurse manager who supports the new OQNs and existing staff including nurse/midwife managers into the workplace, I have witnessed the similarities in the experiences between them and the OQNs and ANs and the nurses in my study. The researcher hoped the dissemination of the findings of this study has assisted individual nurses, health care organisations and the nursing profession to deal with ever changing environment where these nurses work.

6.7 **CONCLUSION**

There was universal consensus among the study participants that the working experiences of the nurses reflected the ideological position of the nurses and that

those particular worldviews are influenced by the wider values and beliefs held within the organisation, profession and Australian society generally. That is, the working experiences of nurses are socially and culturally constructed. Adherence to traditional thinking and traditional workforce transition models, ways of knowing and being in relation to working experiences are represented. Study participants identified many broad ranging factors impacting on their experiences including ideology, economics, politics, history, demography and the way in which cultural diversity is conceptualised and able to be operationalised in the nursing workplace.

The findings of the study on how OQNs and ANs work together depicted working relationships and experiences categorised by complexity and contradiction. In a cross-cultural working environment, with many obvious differences and lack of obvious commonalities, the nurses focussed on their differences and, hence, made mutual understanding even more difficult. The nurses identified that amongst them there were visible and tangible differences, terms of cultural or ethnic origin or language or nursing practice or culture practices. However, finding some common ground, as opposed to focusing on differences, may enhance the cooperation between the nurses. As is shown from this study, the shared experience of being a nurse makes it possible to identify with each other as colleagues rather than rivals. In addition, in the case of the OQNs and ANs, highlighting the common goal of provision of nursing care for patients could be key; their common ground is indeed their professional identity and the mutual goal of providing a safe and quality patient care.

The nurses' experiences while working with each other were intertwined within the context in which they are situated, the ways they constructed and responded to differences and their professional conduct. Dissonance contributed to their uncertainty, challenges to their personal and professional identity and lack of cohesiveness and collaboration among nurses in the workplace. The nurses engaged in acclimatisation,

acculturation and socialisation processes to work out the differences they experienced and to develop a collaborative working relationship to provide patient care as intended and expected by the Australian health care organisations, the nursing profession and the Australian population.

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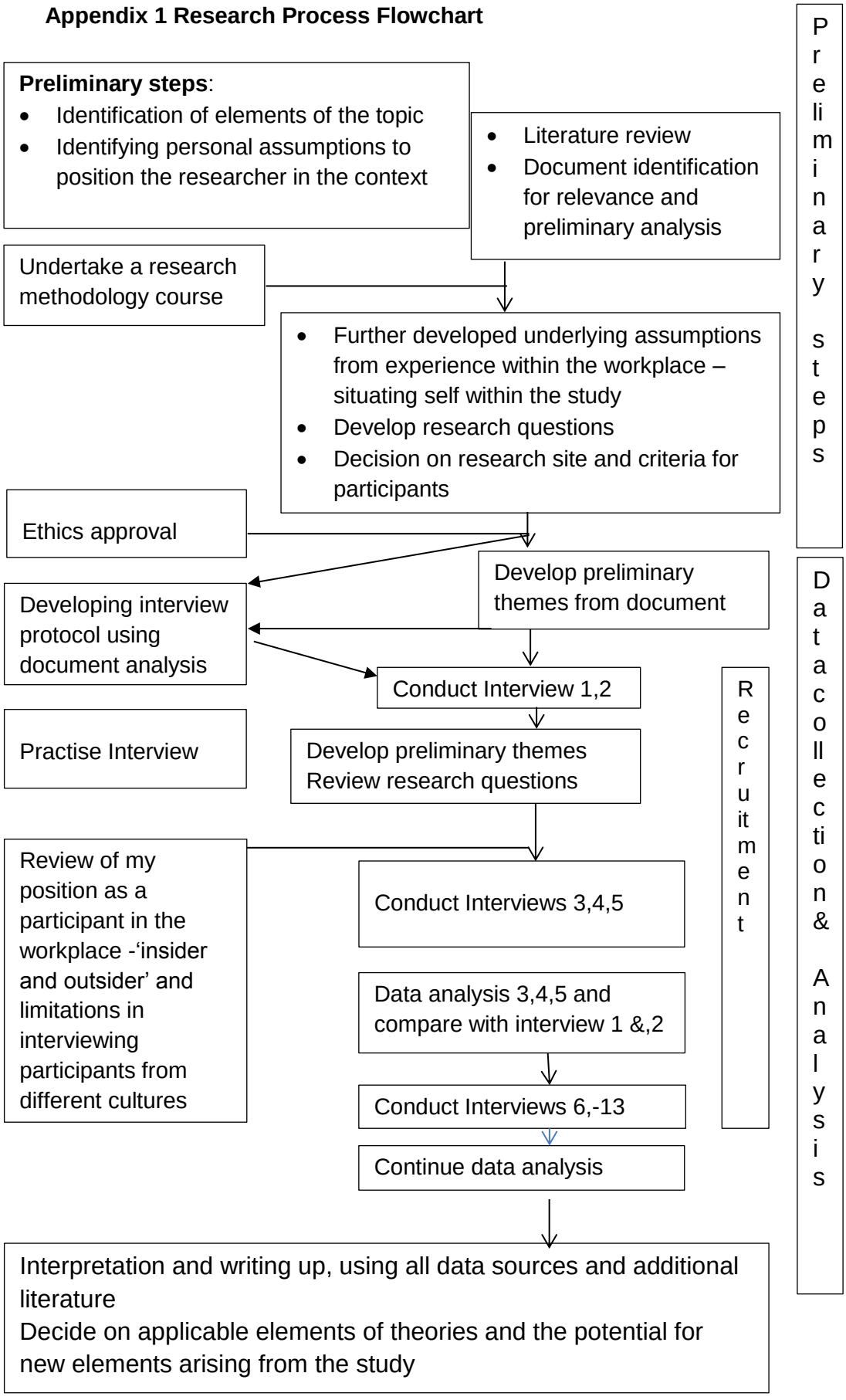
APPENDICES

Appendix 1 Research Process Flowchart



Appendix 2: Participant Information Statement

Conjoint A/Prof Vicki Parker, Dr Sarah Jeong & Dr Terry Joyce
University of Newcastle, Locked Bag 1, HRMC 2310
Ph: 02 4921 4504 Fax: 02 49223290
Email: vicki.parker@hnehealth.nsw.gov.au
Email: sarah.jeong@Newcastle.edu.au
Email: terry.joyce@newcastle.edu.au
Se Ok Ohr (Phd Candidate)
University of Newcastle
E: mail: seok.ohr@hnehealth.nsw.gov.au

Information Statement for the Research Project:

An examination of how overseas qualified nurses and Australian nurses work together in the Australian context.

Document Version 2 dated 20/09/2009

You are invited to take part in the research project identified above which is being conducted by Se Ok Ohr (RN), as part of a Master of Nursing Degree at the School of Nursing and Midwifery at the University of Newcastle. The research is supervised by A/Professor Vicki Parker and Dr Sarah Jeong from the School of Nursing and Midwifery, the University of Newcastle and Dr Terry Joyce, Discipline of General Practice, the University of Newcastle.

Aims of study are,

- To explore the experiences of overseas qualified nurses and Australian nurses working together in a health care organisation, specifically the Hunter New England Area Health Service (HNEAHS).
- To articulate nurses' perspectives of factors contributing to their experiences.
- To explore the mindsets and practices that nurses employ while working together.
- To identify strategies to support nurses in their working environment.
-

Who can participate?

Nursing staff who have been employed in the HNEAHS are invited to participate in this study. We are looking for nurses who meet the following criteria.

An Australian nurse:

- is trained/educated in Australia,
- identifies as an Australian nurse, and
- has experiences of working with overseas qualified nurses while working at a facility of HNEAHS.

An Overseas qualified nurse:

- is trained/ educated and first registered in a country outside of Australia,
- identifies as an overseas qualified nurse, and
- has experience working in an Australian health care context for at least 6 months.

What choice do you have?

Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you decide to participate is your decision and will not disadvantage you in any way or affect your relationship with your employer. If you do decide to participate, you may withdraw from the project at any time without giving a reason. If you withdraw from the study all information provided by you will be destroyed and not used in the study.

What would you be asked to do?

If you agree to participate in an interview, you will be asked to sign and return, via internal mail, the attached consent form in the addressed envelope provided to the researcher. She will then phone you to arrange a date and time for the interview.
The interview will take up to 60 minutes. During that time, you will be asked a series of questions about your experience either as an overseas born nurse working in Australia or as an Australian nurse working with overseas nurses, and asked to comment and answer from your own experience. With some participants, more than one interview might be held as we may wish to explore further, issues raised in the first interview. The information you provide will be recorded on a digital recorder and later transcribed by a transcriptionist bound by confidentiality. At any time during the interview, you may ask for the recording to be stopped and to review the recording and edit or delete sections of it. You may also review the transcript and make any alterations to it. The information you provide is confidential and you will not be identified in any way in any reports or publications that may arise from the findings of the research in which you have participated. You will be invited to bring to the interview photographs, images or a

collage of images that could assist you to express experiences of working with overseas qualified nurses or Australian nurses.

Are there any risks or benefits of participating?

There are no known or potential risks to participating in this study. Should participation in any of the research activities cause personal distress or discomfort, you are invited to contact the Hunter New England Health Employee's Assistance Program (contact No is at the end of this information statement) and will be advised of your right not to participate in the study.

We cannot promise you any benefit from participating in this research

How will your privacy be protected?

All information obtained during the course of the research is de-identified to ensure anonymity and is kept in confidential. Code numbers will be used in place of names throughout the research process. Completed consent forms and identifying data will be stored in a separate locked filing cabinet accessible only to the researchers. On completion of the data collection, all data will be kept in a secure password protected directory for five years in line with University of Newcastle ethics guidelines. After which, all identifying information and data will be destroyed following University procedures for shredding of sensitive documents and by using verifiable procedures for wiping taped interviews.

How will the information collected be used?

Information gathered from this project will be reported in a thesis to be submitted for Se Ok Ohr's Masters in Nursing Degree. It will also be reported in seminars and in-service sessions within the HNEAHS, papers in scientific journals and to the nursing community during conference presentations. Individual participants will not be identified in any reports arising from the project. For example, your name and employment details will not be used in any reports of the study. You will be provided with the summary of the study result if you wish to do so.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, contact the researchers.

If you would like to participate please complete the consent form and return it in the pre paid reply envelope included to the researcher. The student researcher will then contact you to arrange the interview at a time and date convenient to you.
For further information about the project, please contact Vicki Parker on 49855925 or Se Ok Ohr on 0240164747 or 0434070284 (mobile).

Thank you for considering this invitation.
Yours sincerely

A/Prof Vicki Parker	Se Ok Ohr, Student
Dr Sarah Jeong	Dr Terry Joyce

Contact for Hunter New England Health Employee's Assistance Program: Phone No. 49853289

This research project has been approved by the Hunter New England Area Research Ethics Committee, **Reference No** 09/09/16/5.06**.** Should you have any concerns regarding your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to

Dr Nicole Gerrand
Manager, Research Ethics and Governance
Hunter New England Area Human Research Ethics Committee
Telephone (02) 4921 4950,
Fax : (02) 4921 4818
email hnehrec@hnehealth.nsw.gov.au

Appendix 3: Participant Consent Form

Principal Supervisor: Conjoint A/Prof. Vicki Parker
Faculty of Health, The University of Newcastle
Ph: 02 4921 4504
E-mail:vicki.parker@newcastle.edu.au

Consent Form

An examination of how overseas qualified nurses and Australian nurses work together in the Australian context

Document Version 1 dated 31/08/2009

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained. I have also retained a copy of this Consent Form

I have had the opportunity to have questions answered to my satisfaction.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I understand that my personal information will remain confidential to the researchers

I consent to take part in an interview

Print Name: _____

Contact Details: Address:

Phone Number:

E mail:

Signature: _____**Date:** _____

This research project has been approved by the Hunter New England Area Research Ethics Committee, **Reference No** 09/09/16/5.06. Should you have any concerns regarding your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to

Dr Nicole Gerrand
Manager, Research Ethics and governance
Hunter New England Area Human Research Ethics Committee
Telephone (02) 4921 4950,
Fax : (02) 4921 4818
Email: HNEHREC@hnehealth.nsw.gov.au

Appendix 4: Participant Recruitment Flyer

HUNTER NEW ENGLAND
NSW HEALTH

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Registered nurses required

Are you **an overseas qualified nurse** working in Hunter New England Health?

Are you **an Australian nurse** who is working or has worked with an overseas qualified nurse in Hunter New England Health?

If Answer is : **Yes**

You are invited to participate a research study on the experiences of overseas qualified nurses and Australian nurses working together in Hunter New England Health in the Hunter Region, NSW.

What do you need to do?

You will be invited for an interview which will take up to 60 minutes.

Who to contact

for more information on the study and for expression of interest for participation

Name/ Ph No. /e-mail of the Clinical Educator

or

Name/ Ph No. /e-mail Multicultural Health Liaison Officer

Or

Se Ok(SAO) Ohr on 40164747(W) or 0434070284 (mobile) email: seok.ohr@hnehealth.nsw.gov.au

Appendix 5 Protocol for Interviews

The research questions

1. What is the nature of the context and experiences of OQNs and ANs working together in regional hospitals in Australia?

2. What support strategies are available to nurses in their working environment that promote a culture of reciprocity and collaborative working relationships?

Participants are invited to tell their story of working of working with others from a different cultural background in the context of an Australian health care facility. Interviews will begin with asking the general question

- Can you tell me about your experiences of working with Australian nurses/ OQNs in your working place?
- Can you describe what is it like for you in detail and perhaps provide examples of significant events that you can recall that will help me understand your experience?

Some further questions might be included to gain a fuller understanding and explore in more detail particular issues, challenges and to clarify meaning. For example, questions such as

- Why do you think that happened? How could it be different? What impact have your experiences had on you and your practice?
- How did your experience make you feel?

Some more specific examples that may be included are;

- Chronology:" And then? When was that?"
- Detail: "Tell me more about that, that's very interesting"
- Clarification: "I don't quite understand; but you said earlier…"
- Explanation: "Why? How come?"
- Probing phase
    - "Can you say something more about …"
    - "Can you give a more detailed description of what happened …"
    - "Do you have further examples of that …"

- Specifying phase
    - “What did you think then …”
    - “What did you actually do when …”
    - “Have you also experience this yourself …”
        - …”
- Clarifying phase
    - “You then mean that …”
    - “Is it correct that you feel …”

Appendix 6 Demographic Information

An examination of how overseas qualified nurses and Australian nurses work together in the Australian context (For Overseas qualified nurses)

Demographic information:

1. ID No. Name (optional)
2. Gender: Male/Female Age:
3. Country of birth:
4. First language spoken/ preferred language if different :
5. Length of stay in Australia: years months
6. The year registration: Country of origin _____ Australia _____
7. Nursing Education and experiences

7.1 Overseas

Nursing education	a. Hospital based training □ b. Nursing college □ c. University □ d. Other _____
Nursing related work experiences (Length, area of work, position)	

7.2 Australia

Nursing education	a. Hospital based training □ b. Australian Nursing & Midwifery Council competency assessment □ c. University □ d. Other _____
Nursing related work experiences (Length, area of work, position)	

An examination of how overseas qualified nurses and Australian nurses work together in the Australian context (For Australian nurses)

Demographic information:

1. ID No. Name (optional)
2. Gender: Male/Female Age:
3. Country of birth:
4. First language spoken/ preferred language if different:
5. The year registration: _____
6. Nursing Education and experiences

Nursing education	a. Hospital based training □ b. Nursing college □ c. University □ d. Other _____
Nursing related work experiences (Length, area of work, position)	

Appendix 7: HREC Ethics Approval Letter

25 September 2009

HUNTER NEW ENGLAND
NSW HEALTH

Associate Professor V Parker
Research & Practice Development
John Hunter Hospital

Dear Professor Parker,

Re: An Examinatoin of How Overseas Qualified Nurses and Australian Nurses Work Together in the Australian Context (09/09/16/5.06)

HNEHREC Reference No: 09/09/16/5.06
NSW HREC Reference No: HREC/09/HNE/289
SSA Reference No: SSA/09/HNE/314

Thank you for submitting the above protocol for single ethical review. This project was first considered by the Hunter New England Human Research Ethics Committee at its meeting held on **16 September 2009.** This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (2007)* (National Statement) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. Further, this Committee has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review. The Committee's Terms of Reference are available from the Hunter New England Area Health Service website: http://www.hnehealth.nsw.gov.au/Human_Research_Ethics.

I am pleased to advise that following acceptance under delegated authourity of the requested clarifications and revised Information Statement by Dr Nicole Gerrand Manager, Research Ethics & Governance, the Hunter New England Human Research Ethics Committee has granted ethical approval of the above project.

The following documentation has been reviewed and approved by the Hunter New England Human Research Ethics Committee:

- The Participant Information Statement (Version 2 dated 20 September 2009);
- The Recruitment Flyer (Version 1 dated 26 August 2009);
- The Interview Schedule;
- The Demographic Information for Overseas Nurses;
- The Demographic Information for Australian Nurses;
- The Confidentiality Agreement – Transcriber (Version dated 27 August 2009); and
- The Confidentiality Agreement – Recruiting Person (Version dated 27 August 2009)

For the protocol: **An Examinatoin of How Overseas Qualified Nurses and Australian Nurses Work Together in the Australian Context**

Approval from the Hunter New England Human Research Ethics Committee for the above protocol is given for a maximum of **5** years from the date of this letter, after which a renewal application will be required if the protocol has not been completed.

Hunter New England Research Ethics & Governance Unit

(Locked Bag No 1)
(New Lambton NSW 2305)
Telephone (02) 49214 950 Facsimile (02) 49214 818
Email: hnehrec@hnehealth.nsw.gov.au
http://www.hnehealth.nsw.gov.au/Human_Research_Ethics

The *National Statement on Ethical Conduct in Human Research (2007),* which the Committee is obliged to adhere to, include the requirement that the committee monitors the research protocols it has approved. In order for the Committee to fulfil this function, it requires:

- a report of the progress of the above protocol be submitted at 12 monthly intervals. Your review date is **September 2010.** A proforma for the annual report will be sent two weeks prior to the due date.

- A final report be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled. A proforma for the final report will be sent two weeks prior to the due date.

- All variations or amendments to this protocol, including amendments to the Information Sheet and Consent Form, must be forwarded to and approved by the Hunter New England Human Research Ethics Committee prior to their implementation.

- The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:

    - any serious or unexpected adverse events
        - Adverse events, however minor, must be recorded as observed by the Investigator or as volunteered by a participant in this protocol. Full details will be documented, whether or not the Investigator or his deputies considers the event to be related to the trial substance or procedure. These do not need to be reported to the Hunter New England Human Research Ethics Committee

        - Serious adverse events that occur during the study or within six months of completion of the trial at your site should be reported to the Manager, Research Ethics & Governance, of the Hunter New England Human Research Ethics Committee as soon as possible and at the latest within 72 hours.

        - All other safety reporting should be in accordance with the NHMRC's Safety Monitoring Position Statement – May 2009 available at http://www.nhmrc.gov.au/health_ethics/hrecs/reference/_files/090609_nhmrc_position_statement.pdf

        - Serious adverse events are defined as:

            - Causing death, life threatening or serious disability.
            - Cause or prolong hospitalisation.
            - Overdoses, cancers, congenital abnormalities whether judged to be caused by the investigational agent or new procedure or not.

    - unforeseen events that might affect continued ethical acceptability of the project.

- If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform Dr Nicole Gerrand, as soon as possible.

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorisation from the Chief Executive or delegate of that site has been obtained.

Hunter New England Research Ethics & Governance Unit

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(New Lambton NSW 2305)
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Email: hnehrec@hnehealth.nsw.gov.au
http://www.hnehealth.nsw.gov.au/Human_Research_Ethics

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

Should you have any concerns or questions about your research, please contact Dr Gerrand as per her details at the bottom of the page. The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Please quote **09/09/16/5.06** in all correspondence.

The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Yours faithfully

For: Dr M Parsons
Chair
Hunter New England Human Research Ethics Committee

Hunter New England Research Ethics & Governance Unit

(Locked Bag No 1)
(New Lambton NSW 2305)
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http://www.hnehealth.nsw.gov.au/Human_Research_Ethics

HUNTER NEW ENGLAND
NSW HEALTH

28 September 2009

Associate Professor V Parker
Research & Practice Development
John Hunter Hospital

Dear Professor Parker,

Re: An examination of how overseas qualified nurses and Australian nurses work together in the Australian context (09/09/16/5.06)

HNEHREC reference number: 09/09/16/5.06
HREC reference number: HREC/09/HNE/289
SSA reference number: SSA/09/HNE/314

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to take place at the following sites:

- Hunter New England Health

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to the research governance officer;
2. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project, are to be submitted to the research governance officer.

Yours faithfully

Dr Nicole Gerrand
Research Governance Officer
Hunter New England Health

Hunter New England Research Ethics & Governance Unit

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(New Lambton NSW 2305)
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http://www.hnehealth.nsw.gov.au/Human_Research_Ethics

PUBLICATIONS OF THE STUDY

1. Ohr, S., Jeong, S., Parker, V., & McMillan, M. (2014) Organisational support in the recruitment and transition of overseas-qualified nurses: Lessons learnt from a study tour. *Nursing & Health Sciences*, 16 (2): 255-261.ISSN: 1441-0745
2. Ohr, S., Parker, V., Jeong, S., & McMillan, M. (2014) Nursing education to meet the global movement of nurses: from Australian context, International celebration conference for 110 years contributions of nursing education of Ewha Womans University, Seoul Korea
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