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A clash of cultures: a model for supporting adaptation nurses

Doctorate in Education

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Abstract

Non-European Union nurses (overseas nurses), have filled nursing positions in the UK for some time in order to cover short-term staffing problems. It is essential that these overseas nurses are supported during the period of time they are assimilated into their new organisation and cultural environment. This is achieved through undergoing a period of supervision and education called an adaptation programme. These programmes prepare such nurses for working in hospitals in the UK ensuring a level of knowledge and skill equal to or greater than, a newly UK registered staff nurse.

Research was undertaken as a single case study, in one Hospital Trust in England. The data was collected via individual and group interviews. Nurses from retrospective and prospective adaptation groups gave qualitative accounts of their experiences of the adaptation programme and their experiences of working in the UK as registered nurses.

The findings of the research indicate that the experience of overseas nurses working in the UK completing their adaptation programme was often a challenge both for themselves and for their UK colleagues. The difficulties experienced by the nurses were categorised into six main themes. From these themes a model was developed which captures the findings of the research. It is argued that the model will be of benefit to any host organisation whatever the employment context, when developing programmes of support for overseas staff. Finally, suggestions for further research are briefly outlined.

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Declaration:

I declare that the work presented in this thesis is all my own work.

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HOW DID I GET HERE?

This thesis investigates the experiences of overseas (non European Union) nurses who have come to work in the UK as trained nurses. Before being recognised as a qualified nurse and registered with the professional body for nursing, the Nursing and Midwifery Council (NMC), each nurse has to undergo an adaptation programme. This programme is a period of education and training which aims to give overseas nurses the opportunity to be supported during the initial period of adapting to working in the United Kingdom.

This study explores the experiences of a group of nurses completing an adaptation training programme in one Hospital Trust in England. In particular it looks in depth at their experiences of working in the clinical environment.

Wanting to undertake doctoral level study became an aspiration 10 years ago. Due to different influences in my life and career the desire to complete a doctorate has gradually grown and this has enabled me to reach where I am now in producing this thesis.

It was during the MA course work that I really started to get to grips with primary research and studying specialist groups. At the time, due to changes in the nursing curriculum student nurses were no longer sent to the operating theatre as part of their training. I could not understand the logic of this. I was in the very fortunate position of being employed jointly by both a hospital and university as a Lecturer Practitioner in operating theatre practice. I therefore had access both to the student nurses and to those who managed the training.

Consequently I was able, following much lobbying, to get student nurses to theatre for a very short period of time and used this as an opportunity to conduct some research as part of my MA course work. This work was then published nationally in order to try and stimulate some debate in trying to get student nurses into theatre during their training (Walker, 1998; 1999). How much influence my articles had I will never know. What I do know is that in all of the institutions I have subsequently worked, student nurses are encouraged to go to the operating theatre as part of their training and some do have a theatre placement.

It was during the late 1990s that a crisis erupted where there were not enough registered nurses available to fill the number of vacant trained nursing posts in the UK. This led to employers looking for overseas nurses to fill these gaps. Theatres had always had staffing difficulties and this general staffing crisis just exacerbated the problem. My manager went to the Philippines in 2000 and recruited 12 nurses for our department. As the Lecturer Practitioner I was able to commence the students onto the Certificate Level Operating Theatre Skills Course as soon as possible after they arrived.

As a theatre management team we decided that the nurses would benefit from undertaking a course that was focused specifically on theatres, rather than doing a general adaptation course. We wanted the nurses to be functioning as registered nurses in the operating theatre department as soon as possible. Many people in the hospital and university did not agree with us: the feeling of the university was that the nurses should gain general skills first before working in theatre. Our arguments against this centred on why the university felt it was important for operating theatre nurses to learn irrelevant skills. For example, what relevance was there in learning how to fill out paperwork to discharge a patient with complex care needs when the nurses would never see that paperwork again? Also we knew that they would have to spend three months undertaking the general adaptation programme and then spend a further three months being integrated into theatres.

From the theatre manager's perspective it was seen as a waste of money and resources for the nurses to complete two periods of study. They were being employed specifically as registered nurses to work in the operating theatre and the needs of the clinical area were such that these nurses were needed to be fully functioning as soon as was reasonably possible. We managed to achieve this aim and consequently the nurses went straight into theatre and carried out their three month adaptation training programme. As we did not formally study or evaluate what we were doing at the time, the factual outcomes of this decision are not known. What is known is that eight of the original twelve nurses still work in the department and remain very happy.

I supported these nurses as their lecturer for the duration of the course and learned enormously from the experience. Whilst some of what I learned is captured in the findings of this current study, much is left out. My memories of the nurses are of them being very loyal both to themselves as a group and to us as managers. For example, following the successful completion of their adaptation programme, they invited the management team to one of their homes where each of them brought their own families to meet us. Each had

cooked a dish of food (which tasted fantastic!) and each of us was given a gift as a token of their thanks for our support.

These nurses influenced me tremendously, and I was both humbled by the sacrifices they made in order to provide for their families and full of admiration at the relentless way in which they worked. In consequence, I wanted to see if there was something I could do to make future adaptation courses better for the nurses who would follow them. As a result at the beginning of my EdD studies I decided to study adaptation nurses in the operating theatre environment in order to ascertain and affect what went on there.

Unfortunately external influences intervened. These included changing my job to work in another role in another hospital, whilst at the same time, clear signals were coming from the Nursing and Midwifery Council that adaptation programmes were to be standardised and delivered by higher educational institutions. I therefore made a conscious decision to study adaptation nurses across the whole of adult nursing. This I felt would give me an opportunity to feed my findings into any new adaptation curriculum, as well as still being influential in raising the specific issues faced by nurses who work in specialist areas such as theatres. I felt there were three key research questions that needed to be answered and depending on the findings meant I would be able to make a contribution to any future adaptation programmes that the hospital may choose to run.

The three key research questions are;

- 1) Does the adaptation programme offered by one Hospital Trust in England manage the cultural differences between adaptation nurses and British trained nurses?
- 2) How well does the adaptation programme prepare adaptation nurses for working in the United Kingdom?
- 3) To what extent did the adaptation programme meet the cultural and professional needs of the adaptation nurses?

It was from these ideas that my literature review began, which in turn influenced the design of my research and the presentation of my work to be examined at doctoral level. From the findings of the literature review given in chapter 2, a conceptual framework of culture which underpins this study was developed and is presented in chapter 3. From the literature review and the conceptual framework that emerged, chapter 4 outlines the methodology of

case study research, which, following individual and group interviews, uses the method of grounded theory to interrogate the data.

Chapters 5 and 6 present the results from the data collection period and makes sense of the findings by discussing them within the context of the academic literature. From these findings a theoretical model is presented in chapter 7, which can be used to influence the design of future adaptation education programmes.

Chapter 7 also draws conclusions from the work presented in this thesis. It is recognised that it is always problematic to generalise from case study research to a wider population. However, those responsible for integrating overseas staff in a range of employment contexts will I am sure, find that the conclusions will resonate with their own experiences of helping and supporting such staff.

Chapter 8 presents an overall conclusion to the work and the future direction of possible academic study related to this thesis.

Overall, the conceptual framework of 'culture and the experiences of 'sameness' and 'differentness' of adaptation nurses to UK culture' emerged as the key focus of this study.

CHAPTER 2

DESIGN CONSIDERATIONS WHEN DEVELOPING AN ADAPTATION PROGRAMME FOR NURSES

Introduction

This chapter explores the issues that curriculum developers need to consider when planning an adaptation nursing programme. It is essential that programme design acknowledges that adaptation nurses come from different cultural backgrounds with unique life experiences and ensures the educational experience for the adaptation nurses is not only positive for the students but also meets the requirements of the nursing professional regulator, the Nursing and Midwifery Council (NMC). Programmes are expected to contain two distinct parts; the theoretical component, which is delivered by institutes of higher education and the clinical component, which is hands-on work-based learning. Each of these educational components has their own challenges. Consideration needs to be given as to how these challenges can be overcome to ensure an effective educational experience is delivered and educational objectives are achieved.

An initial search strategy was developed to search the Ovid MEDLINE, Ovid EMBASE, WORLDCAT, ERIC, SwetsWise and EBSCO CINHAL databases to find literature electronically. No date parameters were set. The set limitation was that any literature found needed to be in the English language. The terms adaptation nurses, overseas nurses, foreign nurses, migrant nurses, adaptation courses and adaptation programmes were used. As the research progressed, the search strategy was expanded to include diversity, culture, cultural competence, cultural models and cultural diversity. Reference lists from the articles and books accessed, were also used to source different material relevant to the research and the ideas which were being generated from reviewing the literature. As the research progressed, manual searches of different library databases available to the researcher were carried out to source books and articles that had not yet been identified. Every effort was made to use material that had a research base or had undergone systematic review, but given the research topic and the political dimensions which can arise, using information from the popular nursing press could not be avoided. It is acknowledged that in using such material this may weaken the strength of the evidence presented in some parts of this thesis.

NMC Educational requirements

Adaptation nurses are qualified nurses in their own country, but are required to complete a further period of training and education if they wish to work as a registered (qualified) nurse in the UK. The NMC specifies the time period each nurse needs to spend completing their adaptation training before being allowed entry to the register. This period of training is called the adaptation period and the time required to complete the training is usually between three to nine months (NMC, 2007). The time period given by the NMC is based on the country where the overseas nurse obtained their registered nurse qualification and the curriculum they followed. Prior to September 2006 the NMC did not stipulate what the content of the adaptation programme should be, only that the nurses should be 'fit to practice'. This was defined as being that at the end of their adaptation period they should 'have the same professional knowledge base and clinical competence as a newly qualified British trained nurse' (Hawthorne, 2001; UKCC, 2001a; UKCC, 2001b). The only stipulation in terms of academic achievement, apart from their nursing qualification obtained from overseas, was that the nurses achieve a 'pass' on the International English Language Testing System (IELTS) (University of Cambridge ESOL Examinations, 2002). This standard was implemented following damaging media coverage about overseas nurses and their lack of ability to speak and understand English (Leifer, 2002). Until February 2007, overseas nurses needed to achieve the following standards in order to pass the ESOL exam:

1. At least 5.5 in the listening and reading sections.
2. At least 6 in the writing and speaking sections.
3. An overall average score of 6.5 (out of a possible 9).

(NMC, 2007)

This lack of a co-ordinated approach to adaptation training for overseas nurses meant there were potentially different standards required of these nurses by different organisations. Thus nurses working in hospitals next door to each other could have totally different education and training experiences. This is because the curriculum was developed and delivered by the local healthcare institution, resulting in the subject matter potentially being taught with a different emphasis and being assessed to different standards. The NMC recognised this as being a problem. From 1st September 2006 (NMC, 2007), the NMC required all overseas (non EU) nurses to undergo an overseas nurses programme (ONP). This was to be delivered by NMC approved educational providers/institutions. Further, the NMC stipulated that to ensure that overseas nurses were able to demonstrate they have the

same professional knowledge base and clinical competence as a British trained nurse, the educational programme must be delivered at the level of a Diploma in Higher Education (DipHE), which is Higher Education, Level 5, undergraduate standard (QAA, 2008).

Another significant change implemented by the NMC is that of English language testing. As from the 1st February 2007 the achievements in the IELTS tests have been significantly increased by the NMC and now include all nurses who wish to apply to be entered onto the register. The new standards of achievement are;

1. At least 7.0 in the listening and reading sections
2. At least 7.0 in the writing and speaking sections
3. An overall average score of 7 (out of a possible 9)

(NMC, 2007)

The NMC has made it clear that it will not accept applicants who score lower than this standard. The impact of these changes has yet to be evaluated, and will be worthy of future research. For the purpose of this thesis, the changes introduced by the NMC will not be applied directly to findings of this thesis as the data collection was completed prior to the above criteria being put into place.

This research aims to establish what the critical components of adaptation programmes need to be in order to meet the cultural and professional needs of these nurses. This research topic is important in a practical sense, because it attempts to facilitate a dialogue between the healthcare institutions which provide the clinical experience during the adaptation period, and the adaptation nurses who have different cultural and professional experiences gained from different countries. Furthermore, it should enhance the understanding of the educational institutions delivering the academic component of the programme, as to the educational needs of such students.

Seven numbered sections now follow, they describe the requirements of adaptation nursing programmes in order to ensure that they are both educationally robust and meet the requirements of the nursing professional body (the NMC). Additionally, adaptation nurses having come to the UK from overseas have personal and professional needs that have to be met to enable them to function fully in their new environment. This is the focus of this thesis and will also be explored in the sections below.

(1) Supporting adaptation nurses

There is much written about the experiences of adaptation nurses when they move to the UK (for example, Alexis, 2002; Bola et al, 2003; Cook, 1998; Daniel et al, 2001; Gerrish and Griffiths, 2004; Iganski et al, 2001; Taylor, 2005; Witchell and Osuch, 2002; Witheres and Snowball, 2003), whilst others (such as Baj, 1997; DiCicco-Bloom, 2004; Ehrenfeld et al, 1998; Magnusdottir, 2005; Omeri et al, 2003 and Pross, 2003) explore the experiences of nurses moving from one country to another. What these publications do not deal with is how the cultural and professional needs of adaptation nurses have been met by employing institutions. There appears to be little written in the literature to assist nurse managers who support adaptation nurses to manage a culturally diverse workforce through these educational programmes.

Many of the studies have focused solely on the bad experiences of nurses working overseas. It is the aim of this study to present a balanced argument, which captures both the positive as well as the negative experiences of completing an adaptation programme in the UK from the overseas nurses' perspective.

(2) Meeting learners' needs

Essential components of adaptation programmes should include pastoral care issues and the integration of cultural differences to develop the students' social and aesthetic skills in a seamless way. This will ensure that organisational values, policies and practices are directed towards meeting learners' needs and improving their performance. In essence, how the curriculum is planned, implemented and evaluated can significantly influence the quality of the education that is provided (Organisation for Economic Co-operation and Development, 1989). Bennett et al (1996) argue that there is often a large gap between what is intended by external influences including policy makers and what is provided in the classroom. Therefore attention to the curriculum is key and needs to include all stakeholders.

West (1997) suggests that developing a collaborative approach to planning and implementing a curriculum, can be problematic where it is at odds with the prevailing organisational culture. Political perspectives therefore also need to be considered, since changes can entail losses and gains within the organisation and different groups will try to maintain or extend their own interests. For collaboration to work therefore, there needs to be mutual understanding and sharing of experiences and needs between academic institutions and the students who will be accessing the curriculum in order that both groups

have their needs met. Omeri et al (2003) found from their systematic literature review that this can be achieved if the following three components are addressed; 1) Educational strategies, both planning and delivery, 2) Student support, 3) Staff education and support.

For adaptation nurses, Alexis (2002) suggests that besides meeting the educational needs of the student, the curriculum should recognise and value the cultural differences between nurses. By doing this, in addition to having a positive effect on individuals, the cultural awareness in the organisation will be raised. The adaptation nurses will feel valued and there is a real opportunity for mutual learning being generated between nurses from different cultures.

In order to achieve this, Alexis and Chambers (2003b) suggests the most favoured system is the pairing of the overseas nurse with a self-selected 'buddy' or mentor who has a genuine desire to experience and learn from the cultures of others. Mentors or buddies with these attitudes to the culture of others will be self aware of their own cultural norms, values, attitudes and health beliefs and this will generate genuine opportunities for the mutual sharing of knowledge and ideas.

In this study, it is acknowledged that the aim of the adaptation programme is to ensure all of the nurses are successful in meeting the requirements of the NMC in order that they may become a registered nurse. What will also be explored is whether the curriculum and the support networks that have been put into place are adequate for the individuals' needs.

(3) Ensuring an appropriate curriculum

The needs of overseas nurses when undertaking educational studies in the UK are going to be different from those they have experienced back home. This is because the educational system and clinical practice setting of the overseas nurse's home country will be different to that of the UK. As a consequence this could mean the requirements to meet the standards for entry to the NMC register in terms of nursing practice and educational achievement will be different. The curriculum therefore needs to be appropriate to meet these needs. One way of ensuring this is to determine the value, worth or quality of educational provision as a basis for suggesting how it may be improved (Rogers, 1998). The process needs to be in-depth and systematic and able to distinguish between external accountability, professional accountability and the need for internal organisational improvement.

To support the requirement for internal organisational improvement both the implementation and evaluation of that curriculum should be a continual interrelated activity. It should be carried out by the whole community within the organisation and viewed as being integral to the values of good teaching and the expectation of the organisation (Coles, 1997). External accountability requires the educational organisation to have systematic and demonstrable procedures for maintaining and improving curriculum quality and ensuring that students who complete the course do so to the required standard. In doing so, this would satisfy the requirements of the healthcare institutions that invest in the programme by sending nurses to complete the course. Professional accountability requires the educational establishment and the nurse educators (who have their own professional responsibilities) to ensure the curriculum and learning outcomes meet the standards set out by the nursing professional body. The NMC as an external body has prescribed what the adaptation programme should contain. They have stipulated that the adaptation programme is for a set period of time and that the nurses must reach the same professional knowledge base and clinical competence as a newly qualified British trained nurse (Hawthorne, 2001). At the same time, the NMC has given no prescription as to how the curriculum should be delivered. Freeman (1994) suggests that teachers, in collaboration with students and other stakeholders are best able to judge learners' needs. Consequently this puts the educational organisation in a strong position to set their own internal, quality agendas to ensure quality improvements whilst meeting the needs of the external bodies and the professional accountability requirements.

Omeri et al (2003) argue that the way the curriculum is delivered is the most important component in accommodating the needs of a group of students from a wide range of backgrounds. It is recognised that the nurses will have many different learning needs because of their cultural differences and previous experiences gained in different environments. As a result the adaptation teachers may need to utilise different strategies for teaching and learning than those they normally employ.

There are a number of factors which contribute to how an individual learns in a given situation such as a student's background, their motivation and personality as well as how the curriculum is delivered. Learning involves feeling, reflecting, thinking and doing and these factors can affect a student's learning style (Yamazaki, 2005). It is imperative that educators understand how best to teach students with differing learning styles and question how successful learning can best take place. One way to try and address this is to look at the learning styles of individuals.

Arguably one of the most widely adopted and adapted classifications of learning styles are those which were identified by Kolb (Reggy-Mamo, 2008). According to Kolb, the process of learning, otherwise known as experiential learning theory (Joy and Kolb, 2009), encompasses a learning cycle consisting of four modes: (1) concrete experience or situation analysis; this stage calls for openly perceiving and involving oneself in new experiences; (2) reflective observation or problem analysis; in this stage the emphasis is placed on reflecting upon experiences from different perspectives; (3) abstract conceptualization or solution analysis, which calls for constructing theories that integrate observations; and, finally (4) active experimentation or implementation analysis geared to the active use of theories to make decisions and solve problems (Grosse and Simpson, 2008). It is not necessary for the person to start their learning in one mode and go through each of the stages in an orderly manner (Joy and Kolb, 2009). Learning is a dynamic process and an individual will use any combination of the above modes.

Depending on an individual's preference, four basic learning styles emerge which describes how individuals learn and these can be measured using an instrument called Kolb's learning style inventory (ibid). These learning styles are: (1) diverging, learners prefer to make more of concrete experience and reflective observation. They prefer to solve problems by viewing situations from many perspectives and enjoy situations that call for generating a wide range of ideas, such as brainstorming sessions; (2) assimilating, learners prefer to learn through reflective observation and abstract conceptualization. They like to solve problems by inductive reasoning and are best at understanding a wide range of information and putting it into concise, logical form, such as theoretical models; (3) converging, learners prefer abstract conceptualization and active experimentation. They focus on finding solutions to specific problems and rely heavily on hypothetical deductive reasoning and; (4) accommodating, learners prefer active experimentation and concrete experience. They prefer to learn primarily from a "hands-on" approach and experimentation (Contessa et al, 2005; Joy and Kolb, 2009).

Kolb's model was taken up by Honey and Mumford (1998) who developed their own classification of learning styles as well as developing a learning styles questionnaire designed to identify the preference of an individual in each of four learning styles; activist, (learning by doing, characterized by openness to new experiences, egocentric and impulsive), reflectors (learn by observing and thinking about what has happened, tend to be cautious and like to explore things carefully before coming to a decision), theorists (need to understand the theory behind the actions and are logical and rational and dislike

ambiguity) and pragmatists (need to put the learning into practice and experiment with ideas). They tend to be impatient and like to get going with new ideas.

Learning styles have been the subject of research for the past four decades and have come under considerable criticism in recent years for having a lack of core theoretical underpinning (Charlesworth, 2007) and lacking robust validity and reliability (Grosse and Simpson, 2008). These weaknesses are acknowledged by Grosse and Simpson (2008), but they feel that the use of learning style instruments as tools for self-development is now well accepted and can assist with gaining a better understanding of how one learns. What educators need to be aware of is that in using any model of learning styles, they are not used to typecast learners but used to develop learners and extend the choice of learning styles they can use (Reggy-Mamo, 2008). Used correctly, they can contribute significantly to the development of the practitioners that are required in nursing today.

What is clear from the above discussion is that the emphasis of any curriculum should be that it meets the needs of the learners. The organisational structure and policies should support these needs. Using organisational outcome measures including exam results and attrition rates can address this. Whilst these outcome measures provide good quantitative data and could provide early indications that a particular line of study is problematic because of high attrition rates or exam failures, these methods do not measure the level of student satisfaction or educational effectiveness.

It is recognised that a definition of educational effectiveness is very difficult to achieve as there are many different interpretations as to what 'effective' means, although it is suggested that some sort of judgement or measurement is made (Bennett et al, 1996). This judgement can be made in two ways. Firstly it can be made from inside the organisation such as evaluating whether resources processes or organisational outcomes affect student outcomes. Secondly they can be carried out in the context of the wider community, where institutions are compared with each other, by using common standards against which they are all measured. It needs to be recognised however, that no matter what educators perceive as important educational outcomes, these may not be the same as those held by the students. This can lead to complex and competing priorities for both parties which could be potentially damaging for both.

A more holistic approach of educational effectiveness is suggested by Creemers (1997). He feels there are three other outcomes of the educational process besides the outcomes of

skills and knowledge which can contribute to educational effectiveness. These outcomes are;

1) Compensation for initial attributes (equity), where the aim of educational establishments should be to reduce pre-existing differences between students. Against this, Riley (1997) argues that trying to provide equal quality of provision to meet the diverse needs of different student groups is difficult, if not impossible. Dean (1997) agrees this can be a dilemma, but suggests it can be managed with the implementation of clear policies which are regularly monitored to measure their effectiveness.

2) Development of social and aesthetic skills that influence attitudes and educational outcomes.

3) Development of higher order skills such as problem solving and meta-cognitive knowledge and skills.

The Quality Assurance Agency for Higher Education (QAA) has published codes of practice and framework documents. These are in place to support academic institutions assure the academic quality and standards in higher education, by requiring all higher education institutions to work to the same standards of academic rigour (QAA, 2001). There is however, no recommendation as to how key stakeholders should be engaged in the work of the institution to improve its effectiveness. The QAA (2004) does guide Higher Educational Institutions to be 'open and informative about its activities' and recommends that if activities are conducted in this way, then public confidence in the institution will be enhanced. The QAA gives no advice on how this can be done other than by suggesting that institutions regularly survey the students to check that the information they were provided with prior to and during their educational experience was accurate, complete and up to date. They also suggest that students should be given opportunities to give formal feedback on their experience of the programme (QAA, 2004). Following the work by the QAA in revising the quality assurance framework for higher education in 2004, the first national student survey was published in 2005 with the aim to 'gather feedback on the quality of students' courses in order to contribute to public accountability as well as to help inform the choices of future applicants to higher education' (HEFCE, 2009).

It could be argued that the QAA could be more prescriptive in the work streams which should be progressed by academic institutions by giving more specific advice on how to engage key stakeholders in its work, in the same way that the NHS has embraced the

involvement of its key stakeholders (the public and patients) in the running of the NHS organisations, as outlined in the NHS plan (Department of Health, 2000). Whilst the students along with the needs of collaborative providers and purchasers are discussed in the QAA document, there are other key stakeholders including local industry, the public and local authorities, who should also be involved in the decisions made by local academic institutions.

For this thesis the focus will be very much on seeking the views of the adaptation nurses as to whether they felt the adaptation course met their needs and whether the organisational structure and policies supported these needs.

(4) Adaptation education programmes

The need to recruit overseas nurses was driven by the government in the NHS Plan (Department of Health, 2000), where it committed to boost the numbers of nurses by 20,000 by recruiting nurses pro-actively from overseas. Alexis (2002) claims this was achieved in early 2002. This massive expansion in the number of overseas nurses registering with the Nursing and Midwifery Council saw 30,000 new registrants to the NMC register in the three years prior to 2002, 15,064 of these being non-EU entrants in 2001/2002 (Buchan, 2002). This demonstrates that more overseas nurses (50.2%) were being added to the register than British trained nurses (49.8%) (Harrison, 2003). The majority of nurses entering the register in 2001/2002 were from the Philippines (7235 nurses) followed by South Africa (2114) and Australia (1342) (Alexis and Chambers, 2003b).

There have been serious concerns as to the quality of the practice placements for the adaptation nurses, as well as the educational framework. There were reports of too many nurses being crammed into placements, thus reducing the quality of the training offered (Duffin, 2002). Rafferty (2001) feels that many of the problems related to adaptation nurse training were due to the lack of an educational framework along with clear guidelines to employers, resulting in establishments setting up their own programmes using a variety of available sources. This, as Rafferty (ibid) points out caused its own problems because the material was often confusing and contradictory. For example, there exists a set of competencies developed by the Nursing and Midwifery Council in 2004 (NMC, 2004c). This document sets out the standards of proficiency required by all nurses, in order to gain admission to the Nursing and Midwifery Council register. What was not made clear by the NMC is how institutions that ran adaptation programmes should ensure these standards

were being met. To address this, the Nursing and Midwifery Council published very clear guidelines in March 2005 describing the nursing competencies that must be achieved and prescribing the content of the educational programmes (NMC, 2005a). The outcomes of this change will not be visible for some time.

(5) Knowledge and skills development to meet the needs of the professional framework

The NMC is clearly trying to ensure that the skills and knowledge of all nurses meet national practice and academic criteria. Whilst it is good to ensure consistency in terms of standards, this may bring its own problems. Each individual has their own life experiences and learning needs which make them unique, thus national criteria may not be flexible enough to meet those needs. Adaptation nurses will thus have different requirements because of their own culture and the culture of their home countries, which will affect the way they work and think. Consequently, being able to adapt to working in a new environment with different rules and expectations may not be achievable in the time frames specified. Conversely, adhering to a prescriptive curriculum may prolong the period of training for some nurses unnecessarily as their skills and knowledge set may be equal to or greater than that of a newly qualified British nurse, with the only adaptation requirement being the need to be inducted into the clinical area. This is supported by Gerrish and Griffith (2004) who found in their study that there was a big gap between the nurse's previous nursing experience and what was required in the UK. They found that the ways of working, the differences in responsibility, pace of work and the way treatments were given, were all factors to which the overseas nurses had to adjust and had a significant bearing on how quickly the nurses completed their adaptation period. The period of adaptation was significantly reduced if the nurses were adapted in a clinical speciality to which they were familiar.

There is a requirement by the NMC that all registered nurses (whether overseas nurses or not) undertake at least 35 hours of learning activity relevant to their practice prior to the renewal of their tri-annual registration in order to maintain that registration with the NMC and this includes nurses who have completed the adaptation programme.

Post Registration Education and Practice (PREP) was designed to help nurses provide a high standard of practice and care by keeping up to date with new developments in practice (NMC, 2008a). The PREP requirements are that each nurse maintains a personal professional profile of any learning activity that they have undertaken including commenting on the way in which it has informed and influenced their practice. There is no

approved format for the profile and the PREP standards can be met in many different ways. It does not have to cost the nurse any money and there is no such thing as an 'approved' PREP learning activity where the nurse needs to collect points or certificates of attendance. This means all registered nurses should be able to meet the NMC requirements without financial costs to themselves.

Organizations do have monies available to support nurses undertake additional education and training but as with most funding streams, the amount of money available can be limited. So the process for allocating this money to nurses is either in the form of direct competition between nurses or it is allocated in some way by a manager. This process can sometimes be problematic for overseas nurses as they may not be able to communicate/articulate their needs or know what is available to them. Further, they may find no matter what their professional educational needs, even if their manager has acknowledged their needs, they may have no control over how the funding is allocated. For example, Gerrish and Griffith (2004) found in their study, that even if an organisation had a policy to support diversity in the workforce in order to ensure equity of opportunities, this was often not delivered. They found that equity of continuous professional development following the adaptation course was based on the value of fairness rather than need. This meant that adaptation nurses were seen to need the same development opportunities as British trained nurses. Given that adaptation nurses had already received a heavy investment throughout their adaptation period, the view of managers was the need to 'be seen to be fair' and therefore they would give priority of accessing educational opportunities to British trained nurses. This is on the basis of the manager feeling this is the right thing to do, rather than because the British nurse needs it. As a consequence the adaptation nurse is thus treated 'differently' in not having fair access to other learning opportunities. This supports the findings of Black (1994) who writes about differentiating between horizontal and vertical equity. Horizontal equity is concerned with giving equal treatment to equals, with vertical equity involving unequal but appropriate treatment to those with unequal needs.

(6) Cultural support in the academic and clinical settings

In delivering the theoretical part of the adaptation curriculum, educational establishments need to be aware that international students often find they have to familiarise themselves with different teaching styles, different examination and assessment activities and having different levels of academic support to that which they are used to (Wilson, 2002). To compound the situation they have to deal with colloquial language, cultural idioms and

settling into a new life in a new country. All of these are obviously very stressful and need to be proactively managed.

Consequently much thought and planning needs to go into the design and delivery of the curriculum. What Omeri et al (2003) suggest is that however the curriculum is delivered, it needs to be flexible and needs to incorporate many different modes of delivery. They go on to suggest the most favoured mode of delivery by overseas students includes interactive lectures and group-based activities. The least preferred method is the didactic lecture because of the use of English and the misunderstandings that can occur from the use of metaphors and humour, all of which may not be understood by the student. Additionally, the pace at which a lecturer delivers a session can make comprehension difficult in the didactic lecture scenario. Inevitably the learning strategies will be different for each multi-cultural group and will depend on the individuals within the group and their individual learning styles. Flexibility is therefore crucial to the style of the teaching to accommodate these needs.

This changes when the adaptation nurses undergo the clinical component of the adaptation programme as a different set of circumstances arise. Daniel et al (2001) suggest that the overseas nurses' expectations of the nursing role are different from what they actually experience in the clinical area. Also they found that the adaptation programme did not prepare the nurses adequately for their clinical nursing role in the UK. This issue can be overcome if individuals who are responsible for looking after overseas nurses and those responsible for managing the curriculum, do so in a way which honours and respects the variety of beliefs, interpersonal styles, attitudes and behaviours of the nurses. It also needs underpinning by organisational policies, which demonstrate support to these values. By using this as a strategy, nurses from different ethnic groups should feel comfortable and be able to learn from others more easily.

One way of helping the overseas nurse to learn how to work in their new environment is via the 'asset approach'. This is where the cultural difference of the overseas nurse is seen as an asset and not a problem (Alexis and Chambers, 2003a). Gorman (1999) feels that the extent to which students are disadvantaged depends on how much their cultural backgrounds differ from that of the educational institution. Therefore a real effort needs to be made to encourage the integration of different cultural norms into the environment in which the nurses work.

Another way to overcome some of the issues experienced by adaptation nurses is to support them by providing a mentor. Preferably this mentor should have previously completed the adaptation programme as they then have an understanding as to what it feels like to undertake the course. If in addition, the higher education institute supplements this support by allocating a personal tutor who is also from a minority background (Gerrish et al, 1996) then the student will have valuable resources readily available. Unfortunately, the reality is that there may not be the number of mentors who have completed an adaptation programme in the clinical area or tutors from ethnic minority backgrounds in the higher educational institution readily available. Therefore mentor support is likely to be delivered by British trained nurses. It is therefore essential that these British nurses have a genuine desire to support their colleagues in the transition they have to make, not only during the adaptation period but afterwards as well.

Taylor (2005) feels that a mentor should share a common understanding of the issues faced by the overseas nurses and that the overseas nurse should not have to prove anything to the mentor. For example, there needs to be an appreciation as to how highly qualified and experienced some of the overseas nurses are, some of whom held senior positions in their own country. This mentor support according to Gerrish et al (1996) would be invaluable, in particular when the nurse is feeling vulnerable or has to meet challenges for which they are unprepared. Lee (2004) found that the students in her study were suffering homesickness and suggests this was in part due to being away from the usual social support mechanisms both in society and nursing environments and so they were reliant on contacting their families and tutors back home for the support they needed. Bola et al (2003) suggest that without an effective support system in place overseas nurses may doubt their ability to solve problems and function successfully.

At the same time the nurses are being put into an environment where co-workers are expected to accept the newcomer from a different culture and background and this acceptance may not be easy. Bola et al (ibid) suggest that the organisation accepting the overseas nurses needs to put into place robust assimilation plans to integrate the new nurses into their new environment and also to educate existing employees on the benefits of cultural diversity. This may be more easily achieved if there are clearly identified nursing mentors who have had extensive and intensive experiences of working with nurses from different cultures (Leininger, 2000). The role of the mentor and the provision of support in the clinical area for adaptation nurses is key to the nurses' integration into the clinical area and will be a focus of the research findings arising from this study.

(7) Communication and working with others

It is obviously crucial for international healthcare professionals to be able to communicate effectively in English both in writing and verbally. This is clearly outlined by the Department of Health (2004) who give clear guidelines to employers thinking of recruiting nurses from overseas. They advise that all potential employees must be able to communicate effectively to ensure safe patient care and that it is legal for an employer to apply conditions relating to each candidate's linguistic ability. They also advise that where individuals require an assessment of competency in English language abilities, this should be carried out prior to employment. This relatively recent advice has been helpful to employers as previously there was no such clear guidance. Even without such guidance, some employers have been very creative in trying to meet the communication needs of these nurses and some examples are now discussed.

One of the key findings from the Oxford Radcliffe Hospitals NHS Trust study (Campbell, 2001) was that the overseas nurses were mostly concerned about their communication skills and so the team developed their adaptation programme around the theoretical framework of English for Specific Purposes (ESP) to deliver the linguistic and socio-cultural elements of the programme. They found by using this approach enabled all nurses working together to become aware of each other's culturally induced behaviour and allowed a mutual respect to be formed between the different groups. Witchell and Osuch (2002) argue that communication is very closely linked to comprehension of culture and language and found that cultural difficulties arose from language differences. Nurses in their study were from the Philippines with an Americanised version of English. Consequently, the adaptation nurses did not understand simple instructions because their understanding of a word or phrase was not the same as that of the English trained nurse. An example they cite is a simple one of a British trained nurse asking an adaptation nurse to take a patient to the 'toilet'. To the adaptation nurse this request had no meaning; had the term 'rest room' been used this would have been understood. Not only are overseas nurses grappling with the use of different language styles such as the difference between English and Americanised English, but they need to grapple with 'British nursing language' which is a 'secret' language that uses slang which is often indecipherable to outsiders. Slang can be defined as 'words, phrases and uses, that are regarded as very informal and are often restricted to special contexts or are peculiar to a specified profession' (Allen, 1991, p1140). Every group has its own language and codes particularly when people belong to a closely knit group. When isolated from other people, they evolve their own language which is not accessible to others (Fox, 2005). This can therefore

compound the difficulty experienced by overseas nurses in understanding what is going on in the workplace. It can also affect the way they portray themselves to others, as they are not able to express themselves in this yet unlearned language.

Witchell and Osuch (2002) also found the issue of accents, colloquialisms and speed of speech made communication between different cultures very difficult to manage both for individuals and for the organisation. To help with local language difficulties, Leifer (2002) reports on one employer who sent their overseas nurses to college to study local idioms of the Black Country accent and dialect in order to help the adaptation nurses when they worked in the clinical areas.

Alexis (2002) suggests that if British nurses were more tolerant and accepting of the differences in communication between the two groups, the overseas nurses would be very appreciative of the support until they became more conversant with British ways of expression. Interestingly, Lee (2004) found that British nurses working abroad who were not conversant with the local language and dialect relied heavily on recognising and interpreting non-verbal communication and experienced great discomfort because of the language barriers. Omeri et al (2003) feel that specialist terminology is very difficult for overseas nurses and that without a good understanding of the English language, the skills of critical thinking and analysis are not possible. It is therefore essential for the adaptation nurse to understand specialist terminology but this is not possible without acquiring knowledge of the English language in some depth.

Because of this difficulty with specialist terms, courses must have a component to assist students with combining language with critical thinking terminology (Omeri et al, 2003). One method that can be employed to encourage students to build language skills is by keeping vocabulary notebooks that include colloquialisms (rather than dictionary definitions). These can then be used in sessions with a mentor or buddy to form an interactive process of correcting misunderstandings in conversation.

There are also the nuances of non-verbal communication, which can mean different things and convey different meanings depending on an individual's cultural background. Bola et al (2003) suggest that some cultures are high context, which means that people depend on a greater degree of non-verbal communication and favour less formal modes of communication. Japanese, Chinese, French, and Arabic countries are said to belong to high context cultures (Yamazaki, 2005). Whereas, low context cultures rely on the spoken word and prefer more formal approaches. The United States, Switzerland, and Germany are felt

to be representative of low-context cultures (ibid). Yi and Jezewski (2000) give the example that in Korea, which is a high context culture, a person smiling is considered untrustworthy and making eye contact is considered impolite and arrogant. This is because trust building precedes formal communication (Usono and Kuofie, 2006). These behaviours are expected and are seen as being 'normal' in Western cultures, which are low context and so prefer to 'cut to the chase' and launch into formal and explicit communication (ibid).

The above findings are supported by the work of Hofstede (Hofstede and Hofstede, 2005) whose cross-cultural research, conducted in seventy countries for more than thirty years, explains how organizational cultures differ from national cultures and the unexamined rules by which people who live in different cultures think, feel, and act. Hofstede (ibid) explores how national cultures differ on the basis of five different dimensions; individualism-collectivism, power distance, uncertainty avoidance, masculinity-femininity, short term- long term orientation as well as exploring the concepts of culture shock, ethnocentrism, stereotyping and differences in language and humour. All of these concepts are features which will be seen in this research study as it progresses. In particular this study will demonstrate the dimensions of individualism versus collectivism and power distance as described by Hofstede.

An individualistic orientation is found in cultures such as the USA and the UK, where people tend to emphasize their individual needs, concerns and interests over those of their group or organization (Treven et al, 2008). Verbal articulation is used along with explicit logic and linear argument and silence is viewed as embarrassing (Joy and Kolb, 2009). Individuals have a positive attitude and have a tendency towards active experimentation by trying out new things (ibid). The opposite is true of individuals whose countries score high on collectivism, such as Asian countries like Saudi Arabia, Japan and Taiwan (Treven et al, 2008), where one is expected to interact with members of one's group for the collective good of that group and have respect for a hierarchical chain of command rather than those who espouse egalitarian values (Flynn and Aiken, 2002). Joy and Kolb (2009) argue that while communicating, people from collectivist societies pay attention to non-verbal cues and the pace of life is slower, which allows time for reflection.

Some nations accept high differences in power and authority between members of different social classes or occupational levels, while other nations do not (Treven et al, 2008). Hofstede describes societies that are high on power distance tend to value social hierarchies (Joy and Kolb, 2009). That is an individual's role in society is to ensure

socially responsible behaviour and to obey those in powerful positions such as teachers (ibid). Those in low power distance societies find that social relationships are not hierarchically arranged and that an individual is free to question and experiment (ibid).

There has been some attempt to explore how these differences in culture might influence learning styles or preferences and although the research studies are limited in number and breadth, they do provide some valuable insights that are of benefit to educationalists (Charlesworth, 2007; Joy and Kolb, 2009). Joy and Kolb (2009) found from their research that culture based differences can be found in the early days of the educational experience and recommend that educationalists design learning situations that are comprehensible for students from other cultures. Whatever the final design of the curriculum, ensuring it is responsive to the needs of the learners and the organisation they work in, is important both organisationally and politically.

Organisationally nursing has seen the globalization of the nursing workforce since the inception of the NHS in 1948. The recruitment of overseas nurses was steady and intensified significantly in the 1990's (Alexis and Vydelingum, 2009). This has therefore contributed to the increasing prevalence of multicultural teams. It is imperative that the teams engage with each other effectively and understand each other's approach to problem solving and decision making and how their cultures may have predisposed them to certain approaches (ibid). Therefore, managers of nursing need to ensure the curriculum which is purchased and delivered to their nurses is fit for purpose, and enables the integration of overseas nurses fully into the workplace.

Politically, the UK has been faced over many years with an increasingly competitive global labour market for nurses. This has been compounded by policy shifts in the 1990s such as moving nurse education into the higher education setting (Allen, 2007). These changes reduced the number of nurses in the workforce, which led to caring activities being delegated to health care assistants and a drive to recruit overseas nurses (ibid). Also there has been a significant shift from the UK policy on recruitment of overseas nurses (Department of Health, 1999; 2000). Whilst the policy itself remains unchanged, there is evidence to suggest that once overseas nurses are recruited to work in the UK health care system they experience a curtailment in their career progression and opportunities for skill development and training as compared with their UK counterparts (Alexis and Vydelingum, 2009). Training in the form of an induction programme for overseas nurses was considered in the Department of Health's (1999) report, but there was a shortfall in

recognizing the long term implications of the education provision of overseas nurses. Lack of appropriate education is clearly linked to the lack of promotion and clear messages are coming from central NHS departments (NHS Institute for Innovation and Improvement, 2009) that there is a real need for this to be rectified as failure to do this could see the migration of nurses from the UK.

These issues present a real opportunity as well as challenges for educational institutions. There is the modern day management challenge of ensuring the sustainability of the organization by competing with others in the educational market place, while delivering a cost effective curriculum demanded by the operational workforce. To remain the educational provider of choice, and meet the needs of the multicultural workplace, educational establishments need to ensure they are future orientated in both their strategic and operational intent.

Conclusion

From the above discussion, it can be seen that planning a curriculum for overseas nurses in a way that facilitates a transition from the nurse's own country to that of the UK is not easy and requires an in depth understanding of the issues which the nurse faces. Whilst giving support in providing information on such practical items as shopping and the tax system are reasonably straightforward, designing a curriculum that picks up the essential clinical skills and knowledge, along with the subtle nuances of the different meanings of words used in the English language and non-verbal communication signals, is not so easy. These issues will be different for each nurse, as each will come from varied cultural backgrounds and life experiences. These have to be aligned in some way by the curriculum developers to meet the prevailing organisational culture of the host teaching institutions and the requirements of the nursing professional body, the NMC. Consequently, in developing any curriculum for adaptation nurses, the culture and experience of the individual adaptation nurse and the culture of the educational institution and the workplace, need to be considered thoroughly and must be integrated into the curriculum in such a way that it is fit for purpose. Educationalists have a responsibility to ensure the curriculum they design and deliver has elements that the students from different cultures can comprehend, by being delivered in such a way as to match with their preferred learning styles.

The concept of culture is a strong thread running throughout the discussions in this chapter and is clearly a crucial part of designing and delivering a adaptation nursing curriculum that will allow overseas nurses access to work in the UK as a registered nurse. The cultural

interactions for the adaptation nurses are complex and involve their own learning styles, communication styles and personal relationships as well as adjusting to the cultural values of the organisations involved. The next chapter, therefore, will explore the concept of culture and its key features, and use it to aid the development of a conceptual framework on which this research study will be based.

CHAPTER 3

BUILDING A CONCEPTUAL FRAMEWORK: DIFFERENCES IN THE CULTURE OF NURSE EDUCATION AND PRACTICES ACROSS THE WORLD

Introduction

This chapter outlines the conceptual framework of culture and how this affects the 'sameness' and 'differentness' of nurse education and practice across the world. Conceptual frameworks connect all aspects of an inquiry including research questions, literature review, theories, methodologies and methods, data collection and analysis (Burgess et al 2006). Conceptual frameworks act like maps, giving coherence to empirical inquiry and can take different forms depending upon the research question or problem (ibid).

From the literature reviewed so far, it is clear overseas nurses have different needs from those of British nurses. Overseas nurses will have different experiences in terms of language skills, nursing practices and education, giving them identifiably different needs.

Effectively, it is the cultural upbringing of each individual which impacts on what they do and how they react to different circumstances and situations. It is the theme of culture which pervades this research study both from the individuals involved, and the organisation within which they work.

Culture

As previously stated, some attempt must be made to acclimatise the adaptation nurses to British culture and NHS practice during their adaptation period. The cultural background of the academic institution can affect the success of the student in their academic studies (Omeri et al, 2003) taking into account that the adaptation nurses themselves may have a different cultural background from both the host institution and British culture. In defining culture, Allen (1991, p282) states it is 'the customs, civilisation and achievements of a particular time or people'. Alexis and Chambers (2003b, p22) add more to this definition by describing culture as being '...An integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic or social nature'.

Lynham (1992) believes that we all hold uniquely different views of health and illness because they have been developed in part by our cultural beliefs and values, which have been determined by the social context in which we live. These definitions are important in trying to understand and manage the cultural diversity of individuals. It can help individuals from a dominant culture appreciate that life experiences and the way situations are viewed can be different for others. It can also prepare individuals from minority cultural groups to view people, and the situations in which they now find themselves, differently. Withers and Snowball (2003) argue that cultural values and norms of an individual are not a static state but a dynamic process that changes as new situations are experienced. They go on to argue that individuals make adjustments in order to adapt to their new way of life.

There have been several authors who have studied the experiences of individuals trying to adapt to a new culture and noted the adjustments that occur to their behaviour, attitude and values as they go through the process (Leininger, 1991 and Pilette, 1989). There are some authors who warn against using a culturalist approach ('us' learning about 'them') to studying nurses, as it can make it appear that it is the nurses that are the problem (Papadopoulos et al, 1998). That is, it can perpetuate a deficit approach to cultural difference and so engender negative stereotyping of the minority ethnic group (Culley, 2006). Kushnick (1988) also agrees that attempting to understand culture is not productive since it tends to emphasise stereotypes of ethnic difference.

The pros and cons regarding the studying of culture are acknowledged. However, this study is seeking to establish how cultural differences create obstacles to an individual fitting into a new working environment. The study of culture therefore, is felt to be a crucial part of this research. Woods (2003) supports this view that studying culture can have benefits, and feels that that defining culture is a complex process because it tends to revolve around the unspoken feeling part of an organisation or ethnic group. In order to understand what this means, an individual has to see or experience an event in order to learn from it.

Not recognising cultural differences can influence how overseas nurses become assimilated into their new environment. Flynn and Aiken (2002) list some interesting cultural differences between nurses who come from individualistic countries such as the United States to those nurses who come from collectivistic countries of the world such as those located in the Pacific Islands, South America, the Philippines and North Africa. They argue

that individualistic nurses ‘...value organisational attributes that promote egalitarianism, and tolerance of ambiguity and...place less importance on teamwork, supervisors, and uniformity of practice’. In contrast the collectivistic nurses ‘...value teamwork...respect for a hierarchical chain of command rather than egalitarianism and strategies that minimise ambiguity, such as clear policies and uniformity of practice’ (ibid, p. 69). There is a suggestion that these latter values can make a difference for practice including being passive and not very assertive, allowing for example subservience in the nurse-doctor relationship. However this research by Flynn and Aiken (ibid) did not find this was necessarily true, but found that despite cultural differences, nurses share the same global professional values. They feel that managers need to utilise fully the skills and talents of all their nurses, no matter from where in the world they have come. There needs to be support for a professional practice environment which sees nurses as being able to practice autonomously, have control over their work environment and have a collegial relationship with doctors.

There are two points of view as to how cultural needs can be met depending on one’s own position in a given learning situation. The first is how the adaptation nurse fits into and learns to work with British culture and the second is how British culture can meet the needs of the adaptation nurse. For both parties there needs to be a high level of inter-cultural communication where there is a good understanding of the social customs and systems of the cultures involved (Alexis and Chambers, 2003b), but there can be barriers to this. These barriers can be issues such as anxiety, assuming similarity instead of differences and ethnocentrism (Jandt, 2009). Ethnocentrism occurs when we assume that our own ways are best as it reinforces our own behaviour and customs, giving the impression that it is a superior way to act (ibid). However this has a negative connotation as it automatically assumes that other cultures are inferior or incorrect. This can then cause anxiety to arise when meeting others from different ethnic groups, as one is unsure how to act or respond in different scenarios. Students may feel isolated and excluded from the dominant cultural group (Omeri et al, 2003), which can be compounded by having different learning styles and suffering homesickness.

Davidhizar et al (1998) suggest that it is important when teaching overseas nurses that every effort is made to ensure that different cultural aspects are taught and integrated into the educational experience. If this is not done, and if the knowledge is presented in a way that reflects the ways of the dominant culture, this results in the student from the non-dominant culture feeling inferior, rejected, out of place, bored or even hostile. McGee

(1994a) agrees with this but warns of the dangers of attempting to introduce culture-specific information into the curriculum as it encourages a superficial approach to care. It can lead to care being approached in a fashion that can be aligned to the nurse following a recipe on how to look after a patient from a certain background. This approach also ignores the culture of the nurse and the positive contribution they can bring to patient care. The curriculum needs to be delivered within a framework that supports the contribution of the nurse, as well as teaching the culture of the organisation in which they find themselves. Not doing this will make it difficult to avoid stereotyping and prejudice. This approach requires the support of the whole organisation to ensure its organisational processes, policies, philosophy and mission statements, also support these values (ibid).

Culture shock

A set of circumstances when an individual feels isolated or excluded can be described as 'culture shock'. Hogg and Holland (2001) describe this as the experience felt when travelling to a different country, feeling that everything is strange and not being sure how to behave in the new environment. There is therefore, an abrupt transition from a familiar to an alien environment, which involves many major and minor differences in lifestyles and events (Dobson, 1991). The normal cultural cues to which one is accustomed and which allow an individual to function are no longer present, and are replaced by new ones that are unfamiliar. Therefore, moving from one country to another harbours many difficulties and exacts a high price from the individual and can even lead to an identity crisis (Ehrenfeld et al, 1998).

Witchell and Osuch (2002) found that cultural differences were not just about language differences but also a gender problem. They found that some male nurses would not talk about their problems with females, even though a good rapport had been developed between the female course facilitators and managers. This made it difficult for course leaders to help rectify any problems. There are other factors that can be difficult to manage including the fact that the professional role of the nurse is different depending on the nurse's country of origin. For example (ibid), in the Philippines care is technical and skills-focused, with basic care needs such as feeding and toileting being met by families or utility boys. This can cause misunderstandings between different cultural groups and may even cause issues in the nurse-patient relationship.

Pross (2003) describes how different cultural groups can interpret the definition of caring and the role of the nurse differently. She found from her study that there was a perception

that American nursing was very much focused on working with and learning how to run machines. Conversely, in some overseas countries, the focus was heavily centred on caring for the individual, as often the lack of healthcare equipment meant that nursing skills and basic caring were the only tools available.

Alexis (2002) argues that British nurses have a role to play in making overseas nurses more welcome and this can be done by becoming more aware of their own culture, thus they can understand the culture of others. To judge others against what is 'normal' or 'appropriate' to the British nurse can lead to misunderstanding and misjudgement in addition to failure to give recognition to the overseas nurse for achievements. Pearce (2002) reports that whilst British nurses are interested to learn about nursing practice overseas from their overseas colleagues, they appeared to have little respect for the overseas nurses' qualifications and experience.

Gerrish and Griffith (2004) found in their study that there were some difficult cultural issues for the adaptation nurses to overcome. Some reported that British trained nurses were openly hostile and reluctant to help them, which had an effect on the adaptation nurses' confidence and self-esteem. This problem was exacerbated because the adaptation nurses were reluctant to complain to senior staff about the behaviour of others as they saw the senior staff as being from the same ethnic backgrounds as the perpetrators, so consequently were unsure as to how they would respond.

Flynn and Aiken (2002) feel that overseas nurses are not readily accepted by their hosts, because they feel that their own professional values and practices will be undermined by overseas nurses, who have not had exposure to the very highly valued professional practice models used by these host nurses. Equally overseas nurses have their own professional practices and values which are unique to them, but which are little understood by the host nurses.

Yi and Jewewski (2000) suggest that there are other problems that overseas nurses need to overcome, such as differences in styles of decision-making, behavioural norms and role expectations of the host organisation. From their study of twelve Korean nurses working in the USA, they found the biggest problems faced by the Korean nurses, were language and the nature of USA nursing practice. The Korean nurses themselves perceived they particularly lacked skills in the area of problem solving and interpersonal relationships. The culture of problem solving in Korea is to concentrate on working and avoiding explanations when problems occur. This is in contrast to the USA system, where nurses

explain situations in detail, discuss problems and solutions and come to a conclusion. Managing interpersonal relationships in Korean culture is to be concise and brief. The study (ibid) demonstrated that this became problematic for nurses when dealing with patients as they felt their duty was to perform a task requested of them, rather than explain to the patient why they were carrying out a particular procedure. The nurses in the study reported it as being one of the first big problems they came up against, and found it could take them as long as ten years to overcome. On the basis of these findings, the development of assertiveness for some cultural groups may be a necessary skill that they need to learn, both during and after their adaptation period.

Transcultural nursing

For the overseas nurse there are some big challenges to face in deciding to work as a nurse within a different culture from that to which they are accustomed. The transition can be assisted if the host organisation ensures that transcultural nursing is included in the adaptation curriculum. This is where the opportunity is given for the nurse to understand their own biases, as well as learning about those they will experience in the organisation in which they are now working, in order to ensure efficacy of the care they deliver to their patients (Thompson et al, 2000). Leininger (2002) describes transcultural nursing as;

'Focused on comparative care, values, beliefs and practices of individuals or groups of similar or different cultures with the goal of providing culture specific and universal care practices in promoting health or well-being or to help people to face unfavourable human conditions, illnesses or death in culturally meaningful ways'.

(p58)

De Santis (1994) describes this as being the integration of the concept of culture into all aspects of nursing and care delivery, where the nurse is able to step out of or suspend their own cultural traditions, values, beliefs and practices, in order to see the situation as others do. To be able to deliver culturally sensitive care, a nurse is required to be conscious of their own values and beliefs, dispelling any stereotypes they may have, so they can compare them to the patient's beliefs. In so doing, they become sensitive to the perspectives of others and more self aware of the many factors that influence their everyday interaction with the patient (Scholes and Moore, 2000; De Santis, 1994). In fact there will be a need for the nurse to see that the western cultural approach to care, using the biomedical model of medicine which aims to treat illness and preserve health, is different if not at odds with the systems of healthcare delivery with which they are familiar (De Santis, 1994). According to Scholes and Moore (2000) this can only be achieved with both

emotional and cognitive preparation of the nurse. This, they argue is a process rather than an end product which needs to occur in a supportive environment both within the classroom and in the clinical area. Not only does it need to occur throughout initial nurse training, but should be integrated into all educational programmes throughout the workforce and the workplace itself. In trying to balance this argument, overseas nurses also have a responsibility to acknowledge that their culture is different from the one they are entering and they also need to have a desire to learn about the new culture and achieving new cultural skills (Alexis and Chambers, 2003b).

Cultural competence

To achieve competence in transcultural care, there needs to be recognition of one's own values; openness to cultural differences; possession of a person-orientated learning style and use of the cultural resources available (De Santis, 1991). Being culturally competent is considered to be essential for providing care that is culturally appropriate (Hogg and Holland, 2001). Giger and Davidhizar (2008) suggest this is a dynamic process whereby the nurse finds meaningful and useful care delivery strategies, based on the knowledge they have of the cultural heritage, beliefs, attitudes and behaviours of the patients for whom they care. This in turn allows for a higher and more sophisticated level of cognitive and psychomotor skills, attitudes and personal beliefs that lead the nurse to deliver meaningful interventions with their patient regardless of their background. This, Scholes and Moore (2000) argue is very difficult as the nurse is working under their own cultural rules and expectations, which may or may not be shared by others. For the nurse, this means working within their own personal and professional beliefs and values and the values of their patients, along with the ethos of the care environment in which they work.

Cultural competence therefore requires the nurse to be able to know, use and appreciate the effects of culture on the individual patient, in order to address health care problems and help in the resolution of individual, community or family problems (De Santis, 1994). However, there is a danger when implementing the process of transcultural nursing and raising the awareness of each of the different party's points of view, that that is all that it does. De Santis (1994) explains that even if there is an awareness of the issues relating to transcultural care, unless it is fully embraced and accepted by the organisation, then the end product will be that there is no acceptance of the patient's views. This is because the nurses will make no compromises when delivering care, as they will follow the established model of care to conform to the organisation's culture, rather than individualise the care given to the patient based on a cultural assessment.

Beliefs, values and attitudes and their relationship to culture

Culture is how we think, behave, make judgements and decisions and is a learned response based upon 'how we do and view things in our group' (Narayanasamy and White, 2004, p104). Our culture is made up of beliefs, values and attitudes that stem from learned behaviours which children acquire by watching adults and learning the different patterns and rules of behaviour and these tend to persist throughout life (Davidhizar et al, 1998). There is no doubt that the attitudes, values and beliefs that we hold as individuals can impact upon our behaviour towards others who are perceived as being different (Lynham, 1992).

There is a need for the nursing student to explore their own beliefs, as omitting so to do could potentially interfere with a willingness to care for individual patients, or patients with particular health care problems (Lynham, 1992). For example, it could interfere with the way care is delivered, which may be in conflict with the desired approach needed from the perspective of the individual who will be receiving that care.

The values of individual students can affect the way they learn and interact in the learning and working environment. Pacquiao (1995) found that values varied between different cultural groups. For European-American students the values they identified as being core included honesty, truthfulness, straightforwardness, self-assuredness, self-confidence and self-motivation. This Davidhizar et al (1998) feel, underpins the dominant American values of glorifying the human's ability to use, control and master their environment and that any phenomena observed are examined and explained in a rational and reflective way. In contrast, Pacquiao (1995) found that students from ethnically diverse groups espoused the values of mutual inter-dependence and group-centeredness. That is they had smooth interpersonal relations with others, and this was demonstrated by their attitude including sensitivity, respect, loyalty, generosity, a sense of belonging, cooperation, tolerance and accommodation of others. This would be supportive of a culture where maintaining the status quo and promoting harmonious relationships and integration rather than dominance are more important (Davidhizar et al, 1998). Each nurse must recognise that they have both personal and professional values and beliefs which may differ from those of their patients and colleagues. Exploring such differences can help to clarify how their own views shape their expectations for, and of, others (Lynham, 1992).

An essential element of being able to achieve an understanding of the needs of patients from other cultures is an attitude or orientation to the patient which invites their input into

the caring relationship (ibid). This ensures that the patient is assisted in bringing their own views, knowledge and values to the care relationship, in order to manage the situation thus achieving the goals that have been set.

Essentially, in caring for individuals from a variety of cultures and in developing an effective nurse/patient relationship, the nurse needs to be aware of his or her own beliefs, values and attitudes and identify how these may differ from those of their patient. Once these have been established, the nurse then needs to seek ways of working within such differences, in order to deliver the care effectively and in partnership with the patient. If this is not done Lynham (ibid) warns that this can lead to the nurse not taking the views of the patient seriously, particularly if those views are quite different from their own. The consequence of the latter approach to care will be that the nurse will re-educate the patient into adopting the nurse's view of what needs to be done, or the patient will be labelled as being 'non-compliant'.

Cultural models

To facilitate the issues raised above into the nursing curriculum requires a systematic process for doing so, such as using cultural models of care as a framework. There are many models published which promote culturally sensitive practice such as Giger and Davidhizar's (2002) model of transcultural nursing assessment and intervention; Purnell's (2002) model of cultural competence; Littlewood's (1989) anthropological nursing model, to name a few. In situating the focus of this research consideration was given as to which of these cultural models best aligns with the focus of this research study. It was felt that these models were excellent tools for assessing the ethnocultural attributes of an individual patient and their families. They were however not very helpful in trying to build a framework around how to best educate nurses to become culturally aware of themselves and others, in order that they are able to demonstrate the implementation of these values in their everyday work as a nurse.

There is no doubt that the most comprehensive transcultural model of care is that developed by Leininger, whose sunrise model is well-accepted throughout nursing (Glittenberg, 2004). Leininger's sunrise model can help nurses and nurse educators expand their views outside of biomedical factors and to take into account the powerful influences that culture and social factors have on health and care (Shapiro et al, 2006). Whilst an important theoretical model, the practical skills application of Leininger's ideas in practice are arguably diffuse. To overcome this issue and to complement Leininger's work,

Papadopoulos et al (1998, p 178) presented their 'model for the development of transcultural skills' which was underpinned by the principles of anti-discriminatory and anti-oppressive practices. This model describes the four main concepts that are needed by an individual when developing their transcultural skills which are: 'cultural awareness, knowledge, sensitivity and competence'. Whilst Papadopoulos et al (ibid) acknowledge that this model had not been rigorously tested at the time of publication they believed it was a good enabling tool for individuals to use when beginning to develop their transcultural skills. The first stage of the model describes the phase of cultural awareness which requires the individual to examine and challenge their own values and how they are socially constructed. The second stage of the model requires cultural knowledge and understanding to be able to make links between an individual's personal position and structural inequalities. This information will come from many different sources, but learning from others will help individuals to avoid making ethnocentric judgments and the power of professionals and medicine in social control. The third stage requires development of cultural sensitivity which Papadopoulos et al (ibid) feel can only be achieved if patients are treated as true partners in the caring relationship and that real care choices are offered to them. This stage of the model requires excellent communication and interpersonal skills and building a trusting relationship with that patient. The final stage is cultural competence where the achievement of anti-discriminatory and anti-oppressive practices is achieved. It is the ideas from Papadopoulos et al (1998) and Leininger (2002) that will be used to situate the model which emerges from this research study as it progresses.

The models of care presented above started to emerge the 1980's along with the publication of a significant body of published literature on the theories and understanding of transcultural nursing (Glittenberg, 2004). As a consequence Glittenberg (ibid) argues that cultural awareness and transcultural nursing is now so well established, that it is now viewed as being just good nursing practice. As a consequence of this, a new debate has been triggered questioning whether there is a need for a separate body of transcultural teaching and practice in nursing. Underpinning this idea, Glittenberg (ibid) argues that the recent high rate of migration around the world has led to an increase in health disparities. The focus for nurse researchers now needs to be on helping to reduce these health disparities which can be achieved by engaging in a transdisciplinary, transcultural health care approach. This is supported by Chapman and Berggren (2005) who argue that there are deep and persistent racial/ethnic inequalities in health status and health care and that a growing awareness of these disparities has 'fuelled a cross-disciplinary debate about

appropriate approaches to these disparities in public health research and policy discourse' (p145).

Glittenberg (2004) suggests that nurses need to respond to this new challenge of ethnic identities being changed as well as languages and family structures which were not known even a decade ago. At this time, the 'minority' patient culture prevailed. In dealing with the health and illness of these minority groups, biomedicine was the predominant model of care. There now needs to be a move towards the formulation of new models of treating illness and disease (as well as promoting health) which includes looking at social as well as biological factors (Chapman and Berggren, 2005). Chapman and Berggren (ibid) go on to discuss how bio-cultural anthropologists have been able to demonstrate links between health status and socio-cultural variables. One example cited is where medical anthropologists were able to contribute to public health program developments as they were able to demonstrate that individual health behaviors were shaped by 'social networks, access to material resources, social capital, household and community dynamics, culture shifts in formal and informal institutions and policy changes' (p 159). Another example Chapman and Berggren (ibid) cite is the work of Schell and Czerwinski who studied a minority group who experienced disproportionate exposure to environmental toxins, including lead. Lead exposure in early in life can impair neurological development, resulting in poor educational and occupational attainment. During pregnancy, inadequate maternal nutrition increases fetal lead exposure by mobilizing lead stored in the previously exposed pregnant woman's bones, thus exposing the next generation to lead-induced damage in utero. Without understanding the background it would be easy to draw conclusions that this disorder of poor educational and occupational attainment was hereditary and so a biologically determined condition, when in fact it is a socially derived condition caused by avoidable pollutant exposure.

Using a transdisciplinary, transcultural, biosocial approach to care, will encourage nurses to think outside of their own discipline and their discipline-bound thinking (Glittenberg, 2004). As a consequence of this, it will extend the knowledge nurses have when delivering care, which can only be a good thing.

Conceptual framework

The literature reviewed has discussed the many personal and educational experiences that overseas nurses have undergone when moving to another country to practice as a nurse. In turn this has helped developed the conceptual framework for this study. The focus has

been on overseas nurses coming to the UK to complete their adaptation programme, although research from other types of exchange programmes from across the world has also been used to inform this discussion. What has become evident is that nurses make clear comparisons to their home culture and experiences as a nurse, by evaluating what is the same and what is different from home and comparing it to the new environment in which they find themselves.

This would support the theory of 'sameness' and 'differentness' as first identified by Leininger (2002) between nurses of different cultures who come together in one place. In not understanding these concepts issues can occur. Leininger (2000) who it could be argued is the founder of the concept of transcultural nursing, claims that it is the differences and similarities between human beings that provide the wealth of new and meaningful insights about culture and care. She (ibid) believes that it is these concepts that lead to cultural clashes, conflicts and imposition of practices and argues that nursing and the nursing profession has its own set of beliefs, values and practices. Nurses share these different aspects of nursing globally; the only difference is between the cultures of the nations where this nursing is delivered.

The research reported in this study is based on the conceptual framework of culture and the way 'sameness' and 'differentness' were evident during the adaptation programme. Its main purpose is to help overseas nurses, host country nurses, healthcare institutions and nurse education providers reduce the barriers between the different groups. It aims to achieve this by exploring the experiences of working in the UK as a registered nurse and trying to make sense of how the experience of 'sameness' and 'differentness' impacts on the adaptation nurse's role both as a nurse and as an individual.

In particular, this study looks at how adaptation nurses and host country nurses can be educated to find commonalities with each other in order to become more culturally aware. This in turn will not only help when working with colleagues from other cultures, but in nursing patients from different cultural backgrounds.

By focusing on 'sameness', it aims to influence how the different methods of nurse education and care delivery can be taught and practiced in different cultures. By focusing on 'differentness', the study aims to contribute to the knowledge of what it feels like to be an adaptation nurse from a different culture.

By understanding each other's cultures, making some adjustments, developing a different way of thinking and understanding others from a different culture, then the 'differentness' between the two groups can be translated into 'sameness' and many of the cultural barriers that are present can be overcome. This Leininger (1994) feels has to be a priority, as health reforms are now universal and healthcare is delivered in a multicultural world. She also recognises that this is an issue which is not unique to nursing and whilst not an easy task, efforts must be made to prioritise culturally congruent care, which can only be delivered if transcultural education is embedded in the educational curriculum.

Conclusion

This chapter has sought to obtain from the literature what cultural issues have been experienced by overseas nursing students. It has been found that these issues are very complex and open to many interpretations. This in the main is due to them being very much based on an individual's life experience, experiences as a nurse and their personal and professional values.

Many of the issues raised in this chapter can be resolved by host organisations by ensuring the curriculum meets the needs and different learning styles adopted by different students. More challenging is to ensure that both the adaptation nurses and staff in the clinical areas are more culturally aware, in order to ensure that the adaptation nurse becomes integrated quickly into the team.

To give a structure to the model which will emerge from this study, different nursing cultural models were explored. On the whole these were found to be useful tools for nurses to use for care delivery, but not so helpful for nurse education and the design of the curriculum, which is the focus of this study. The models developed by Leininger (1994) and Papadopoulos et al (1998) were felt to be much more aligned to this research study, as they were focused on the skills and knowledge nurses needed to become culturally competent practitioners. In future proofing the model which will emerge from this research study, the views of Glittenberg (2004) were also considered. Glittenberg (ibid) argues that there needs to be a new approach to nurse education which encourages nurses to think outside of their own discipline, and their discipline-bound thinking. This can be achieved by an educational programme which is transdisciplinary and focuses on transcultural health care approaches.

The conceptual framework of culture applied to individuals and the organisations that support them and comparing and contrasting their 'sameness' and 'differentness', has

informed the structure of this research study. The research questions for this study are based on the need to explore the educational and professional aspects of an adaptation programme. They were achieved by investigating aspects of the UK experiences that are the same and those which are different from the adaptation nurses' home country.

These investigations assist in clarifying the different interactions that occur between host nurses and overseas nurses. In turn, they inform the findings and the recommendations arising from this research study in order that they can be shared with educators and practitioners who are involved with adaptation nurses and adaptation nursing programmes.

The material gained in compiling this chapter informed the decision that the research enquiry would use the methodological approach of qualitative research to collect the appropriate data. This is because the requisite information needed to be obtained from the nurses themselves and thus required them to talk and describe their personal journey of coming to the UK to work as a nurse.

The next chapter describes the qualitative methodological approach of case study research that uses the method of grounded theory to interrogate the data collected. The data collection methods chosen are individual interviews, group interviews and vignettes and the advantages and challenges of using these methods are also explored.

CHAPTER 4

METHODOLOGY

Introduction

This chapter discusses how this research study was designed. It describes the rationale for using a case study approach and the advantages and disadvantages of using interview guides and vignettes as data collection tools. This chapter explains how the data were analysed using a grounded theory approach (Glaser and Strauss, 1967) and will explore the ethics, reliability, validity and generalisations which have arisen from the research study design.

Research focus/questions/aims

The literature reviewed yields some interesting insights into the universal experiences of immigrant nurses from a wide range of countries including for example Russia, Iceland, Australia and the Philippines; however, none has looked at what personal, cultural and professional experiences have occurred in the clinical area during the adaptation programme. The focus of other studies has been more geared to the actual delivery of the curriculum and the results of the evaluation of that programme.

One of the aims of this research therefore, was to develop an understanding of the personal and professional experiences encountered by overseas nurses during the clinical component of the adaptation training programme in one Hospital Trust in England. The design of the adaptation programme was that the nurses would initially complete a two week induction programme in the classroom setting (phase one). This theoretical component of the course covered communication skills, core Trust policy information such as infection control and blood transfusion and key professional issues such as documentation and record keeping. Phase two consisted of ten single classroom study days presented throughout the duration of the adaptation course, with a heavy focus on communication skills which took eleven of the twenty sessions available. The nine remaining sessions again addressed professional and organisational issues such as older people training, clinical governance, preceptorship and care planning. Once in the clinical area the adaptation nurses were required to send a weekly report to the adaptation course manager giving a brief overview of what they had been doing in the clinical area and what they had learned, as well as giving them an opportunity to raise any issues that were concerning them.

The clinical component of the programme required the nurses to be based on one ward or department where they were assigned a mentor. This mentor would support the adaptation nurse in the workplace for the duration of the adaptation programme. There was a requirement on the mentor to conduct an orientation and induction to the area, and document that this had occurred. This was to be followed by three 'formal' interviews between the mentor and adaptation nurse to check on progress against previously agreed learning needs and to assess for any new needs that needed to be addressed. These interviews occurred one month into the course, between two to three months into the course and just before final completion of the course. It is this clinical component of the adaptation programme that this research study will focus on in particular.

The research questions posed in chapter one were focused on establishing how an adaptation programme offered by a single Hospital Trust managed the cultural differences between adaptation nurses and British trained nurses. This information was gained from collecting data in a planned and systematic way, by asking adaptation nurses how they felt that the adaptation programme had prepared them personally, culturally and professionally for working in the United Kingdom. In consequence, the data collection tools were developed to collect information in order to answer the following research questions:

- 1) Does the adaptation programme offered by one Hospital Trust in England manage the cultural differences between adaptation nurses and British trained nurses?
- 2) How well does the adaptation programme prepare adaptation nurses for working in the United Kingdom?
- 3) To what extent did the adaptation programme meet the cultural and professional needs of the adaptation nurses?

Overall research design/strategy

This study applies the principles and methods of qualitative approaches to participant perceptions and curriculum evaluation. The research design chosen was that of a case study approach using data from group and individual interviews and using interview guides and vignettes as tools to assist with data collection. The concepts encompassed in the Enlightenment Model were felt to capture the essence of this study. The Enlightenment Model is described as helping to shape practice through providing knowledge and ideas that can influence the ways in which policymakers and practitioners think about their work (Hammersley, 2002). This research strategy is described by Weiss (1979) as being a

process by which new information and knowledge percolates out in a diffuse way. This gives different perspectives and ideas which play a significant role in influencing policy and the policy making process. The reason for this is; it is not the findings of a single study or a group of studies that directly affect policy, but the concepts and theoretical perspectives derived from such research. These percolate through the policy environment and shape the way policy makers think about issues. Policy makers use research materials to influence their decisions but will rarely be able to cite any one particular study that has informed their work. It is the collective information that gives policy makers a sense of the ideas and orientations of current issues that need to be tackled (ibid). In other words collective research findings sensitise policy makers to new issues and help to turn what may be perceived as non-problems into policy problems or vice versa and as a result can overturn accustomed values and patterns of thought.

The choice of a discipline-focused inquiry, using the Enlightenment approach for this study, was derived from the fact that the group studied are overseas nurses. The aim being to generate general-purpose knowledge from their experiences, which will influence curriculum planners and educational providers and as a consequence make a contribution to changing current practice. It will also play a part in informing the research literature on the educational experiences of overseas nurses. Iganski et al (2001) suggest from their research that the recruitment of ethnic minority groups into nursing and midwifery is fragmented and that little is being done to ensure a systematic strategy to improve education for minority groups. This is supported by Alexis and Vydelingum (2005) who found from their systematic review of the literature, that there are significant deficits in the research available on the experiences of overseas black and ethnic minority nurses and that further research is warranted.

The aim of this study was to explore how well the personal, cultural and professional needs of overseas nurses were met through a case study of an adaptation programme. To ensure the research was manageable within the available resources, it was essential to narrow the focus of its scope. Therefore, one Hospital Trust was chosen for the study, which for convenience to the researcher was the institution in which she worked at the time the research was conducted. This had advantages of easier collaboration with others and easier access to the research participants and staff. This arguably could meet the ethical point that regardless of the outcome of the study, it will make a worthwhile contribution to the life of the institution (Hammersley et al, 1998). Studying only one organisation ensured that the depth of understanding of an individual research site was explored more thoroughly. It

could however be argued that by focusing on only one research site, the application of the findings to other institutions may be affected. This is because the findings gained from studying only one site would be less generalisable, and so less useful, than if the research outcomes were obtained from several sites. Burgess et al (2006) however point out that it is not necessarily the generalisability of the research findings that may be of benefit to others, but the relevance of the findings to professional practice and its usefulness to others in a similar situation which counts. It is this latter point, which most influenced the researcher for this study. Whilst the findings of this research will be of benefit for the institution in which she worked and the ways in which the institution looks after their adaptation nurses, it will also be useful for other institutions to use in exploring their own provision of support for similar groups of nurses or other staff working in their organisations. Hence generating generalisations from this research will be invaluable to others.

Choice of research design

Why a case study design?

A case study design was chosen for this study as it lends itself to a detailed research enquiry into a single social unit (Payne and Payne, 2004). In this research study, this means a single Hospital Trust (physical place), with the people making up that unit (adaptation nurses) who are differentiated from others who are not part of it (British trained nurses).

Research using a single case study contributes to knowledge by using the uniqueness of that case study as a powerful example of generating new ideas and testing theoretical statements (ibid). The case study methodology is principally concerned with the interaction of factors and events, which may be hidden through normal observation or research methodologies such as large-scale surveys (Bell, 2005).

From a single researcher's perspective, undertaking a case study gives an ideal platform from which to explore underdeveloped ideas which the researcher wishes to examine in more depth. They are more manageable for a single-handed researcher as the focus is on only one case, albeit studied in depth, enabling the work to be completed much more easily particularly if there is a limited time scale (Payne and Payne, 2004). This approach therefore was very relevant for this study as the researcher was working alone, and had a limited time frame in which to complete the work.

Research techniques for data collection –Interviews or questionnaires?

Both the research techniques of interviews or questionnaires have strengths and weaknesses. The advantage of using interviews to explore perceptions and experiences is that it avoids the pitfall of using questionnaires alone. Information obtained from surveys can sometimes be very superficial, as they tend not to probe too deeply into human behaviour and feelings (Polit and Hungler, 1999). Also the use of surveys to measure attitudes has its limitations as pointed out by Kirk-Smith (1998);

Questionnaire research is commonly used to identify what people do and what influences their behaviour. It is often assumed that questionnaire responses accurately reflect both behaviour and influences on behaviour. In practice this depends on factors such as what is being asked, the situation, why people think the questions are being asked; that is their views about the nature of the research and the use that will be made of it and how anonymous their comments will remain.
(p205)

Kirk-Smith goes on to say that great caution should be taken when interpreting opinions, values and attitudes derived from surveys because of these reasons. Further, high response rates are more difficult to achieve with self-completed surveys than by individual interviews (Parahoo, 2006). The use of a questionnaire as the main research tool was considered but was rejected for the above reasons and the fact that all of the nurses in the study originated from outside of the UK. It was assumed that English would not be the first language of the potential participants and so this could cause some difficulties in understanding the questions posed by a questionnaire. It was felt that a critical component of the data collection was to ensure that the language of the questions was understandable to the participants, and consequently it was felt that interviews were essential. Using interviews would also allow opportunities for the participants to clarify the meaning/interpretation of questions. In addition, it allows an opportunity for the answers given by participants to be probed by the interviewer for deeper meaning, as the interviewer can clarify points and investigate motives and feelings, in a way that surveys never can (Bell, 2005).

It is acknowledged that interviews are time consuming and are a highly subjective technique which can lead to bias (Wragg, 2002). When conducting interviews an important point to note is that an interviewer's own status, purpose and function can lead to a distortion in the answers given by respondents. This would be based on how the respondent feels about the interview, whether they are apprehensive for example, or how they feel about the interviewer, for instance being afraid of being 'judged'. Parahoo (2006) warns that the social and personal characteristics of the interviewer can affect the answers

which participants give (personal reactivity) and that age, sex, social class and race/ethnicity can be a barrier to an honest response. They suggest that some people, who would not agree to being interviewed, may have replied to a survey and point out that an interviewer can sometimes constitute a major barrier to data collection from interviews. It is also acknowledged that the interviewer needs skills in the technique of interviewing and has to show genuine understanding and empathy with the interviewee in order to build up trust (ibid). This is particularly important for this type of study where the research aims to penetrate the 'real' self and seeks to find innermost views based on personal needs and experiences. An interviewer therefore needs to be thoughtful, sensitive and alert to any distress which may be caused and have the skills to diffuse the situation if necessary (ibid). In order to try and overcome these issues, provision was made to carry out some interviews in a group setting. This would mean the researcher would visit the group regularly to conduct the interviews, ensuring that the nurses would become more comfortable with the researcher over time and so would be more likely to share their experiences. Despite these potential problems it was felt that face-to-face interviewing is a method that can yield a rich source of information.

To support the researcher in carrying out the proposed interviews with the adaptation nurses, it was necessary to design an interview guide. An interview guide rather than an interview schedule was used, as this allowed the interviewer to work to a set of topic areas, but there was flexibility in the order the questions were asked and the way in which they were asked (Seale 2004). Given the above discussion and due to time constraints and practicality it was decided to conduct the research for this study in two distinct parts. The first part was a cross sectional cohort study using individual face-to-face interviews of a retrospective group of adaptation nurses using an interview guide informed by the literature reviewed. The information from the first phase interviews informed the interview guide and vignettes for the second phase of the research process which was conducted using semi-structured group interviews with a prospective cohort of adaptation nurses, as a longitudinal study.

The purpose of the research tools used

The interview guides were used as prompts to gather information from the adaptation nurses. The vignettes were used as a data collection tool to obtain perceptions, opinions, beliefs and attitudes based on different scenarios. Barter and Renold (1999) suggest vignettes are presented to the research participants as stories or explanations of situations

that are relevant to their clinical practice. This according to Angelides et al (2004) will encourage and enable them to reflect on recent experience a little more easily. Furthermore it is acknowledged in the literature (Wilson, 2002), that the traditional medium for disseminating nursing knowledge and skills is via oral communication by using stories and vignettes. These stories are a rich source of learning about nursing practice and such exchanges assist nurses with developing a greater understanding of the practice of nursing. They were therefore felt to be a useful tool for obtaining such evidence from the nurses in this research study, particularly as it is a method of information sharing with which they are familiar.

The two stages of the data collection periods for this research study using the above tools are now discussed.

Stage 1

Retrospective design

The first stage of the data collection process was to use a retrospective design to interview nurses who had completed an adaptation course at the same Hospital Trust in England between April 2002 and September 2004. The purpose of the interviews was to encourage them to reflect on how their personal, cultural and professional needs had been met during the adaptation course. The data collected was then used to inform the research design and tools used in stage two of this research study.

The semi-structured interviews were conducted with a convenience sample of adaptation nurses. These nurses were deliberately selected to reflect the characteristics of interest to the researcher (Bowling and Ebrahim, 2005) and could also therefore, be considered a purposive sample. The use of a retrospective group was felt to be important, as the nurses would have had time to reflect on their experiences and make some sense of them. It could be argued that the memories of the personal, cultural and professional issues experienced by these nurses may now not be so acute and they may have become culturally sensitised and have already adapted into the new environment in which they have found themselves. However, it was felt that this retrospective group of nurses, even if they had become 'culturally sensitised', they would still have valuable information that could help the researcher develop the research tools for the main study as well as gain some valuable insights into their experiences.

Cases/participants, including sample size and structure

The aim of this part of the study was to interview the participants, with the purpose of using the findings from this group to help develop the interview schedule and vignettes for the main study, rather than being an in depth study of this group. In consequence, only a small number of nurses were required to participate and it was thought that 10% (12) would be a reasonable sample. There were however two problems related to achieving an initial workable sample size for this part of the study.

Firstly, obtaining accurate information on the current whereabouts of the nurses who had adapted in 2002-2004 period proved to be problematic, as the database kept by the adaptation nurse manager was not up to date.

Secondly, the researcher needed to decide how many nurses of this first group should be offered an interview in order to keep the project manageable.

Because of the difficulty of knowing the current location, it was decided to offer all 120 nurses on the database the option to participate in the initial (retrospective) interviews. This was done knowing there was an inherent risk that too many would wish to take part. If this were to occur, there was always the option of asking these nurses to participate in a group interview, or alternatively, the option of thanking them for their interest, explaining the study was up to the allocated number of participants. An invitation letter (Appendix 1) and an information sheet (Appendix 2) was sent to all 120 nurses on the database. From these 120 invitations, the responses received are shown in table 4.1 below;

Table 4.1: Invitation to take part in the interviews

Outcome	n
Wished to participate	10
Letters returned as being 'undelivered to addressee'	7
No response	103
Total	120

Of the ten nurses who volunteered to be interviewed; only six turned up at the agreed time and date of the interview and one withdrew consent at the time of the interview. In total therefore, interviews of five nurses were analysed in detail.

The demographics of the students interviewed are shown in table 4.2 below;

Table 4.2: Demographics of nurses interviewed

Age range	32 – 47 years old
Females	3
Males	2
Country of origin	Zimbabwe Ghana Pakistan Mauritius x 2

The nurses' experience, prior to coming to the UK, ranged from 4 years to 20 years as a qualified nurse. One nurse had previously worked in Kuwait and one nurse was currently undertaking a degree.

Methods of data collection to prepare for stage 1

Consent was obtained from the respondents at the time of the interview (Appendix 3) using the information sheet (Appendix 2) which had been sent previously to the respondents. The purpose was to ensure that they were conversant with the information they had been sent and understood what they were consenting to. The interviews were carried out in a semi-structured manner using the pre-prepared interview guide (Appendix 4). The interviews were recorded using an omni directional microphone attached to a tape recorder and transcribed immediately after the interview. This method was used as it is acknowledged that there are limitations in taking notes during interviews. The use of digital recording had been considered as a more reliable and easier method of recording interview material, but was excluded due to being cost prohibitive at that time. Throughout the phase one interview period, attention was devoted to maximising the ease with which participants were able to answer the questions and ensuring there was a logical flow to the questions, allowing the interview to proceed as a conversation, rather than a set of questions.

The data collected via the individual interviews were analysed using the process of constant comparison (Glaser and Strauss, 1967). This grounded theory (inductive) approach sees theory derived from, or 'grounded' in, empirical data (Seale, 2004). This is conducted by comparing one set of data with another in a rigorous and systematic way in order to identify significant events or words leading to the identification of theoretical categories (equivalent to themes or variables) and their properties (in effect their sub-categories) (Dick, 2005). This process of coding and integration continues until theoretical saturation occurs. A point will be reached when the interview data and data from other sources adds nothing to what is known about that category, its properties and its

relationship (ibid). That is, the category is worked until it is 'theoretically saturated' and there are no new properties or interactions occurring (Seale, 2004). At this stage of the process the researcher goes out of their way to look for groups that stretch the diversity of the data as far as possible, just to make sure that saturation is based on the widest possible range of data in the category (ibid). Once saturation has occurred, the coding for that category ceases. Care needs to be taken when making the decision to cease coding as inadequate theoretical sampling can easily be seen, as the theory associated with it is weak and not well integrated and has many unexplained exceptions (ibid). This process of data analysis and the generation of data helped to determine the content of the phase two interview guide for the prospective group interviews. In particular the researcher was looking at the data generated from the phase one interviews to determine;

1. If the questions were adequate and generated the most appropriate types of answers sought, based on the literature that had been reviewed to date.
2. There was a common understanding of terminology used in the questions

Stage 2

Prospective design

The second phase of the research involved conducting semi-structured group interviews with a prospective cohort of nurses, as a longitudinal study. The aim was to interview the nurses at regular intervals for the duration of their studies (January to July 2006) in order to source a richer set of views and experiences and generate story-telling events, to help create theoretical insights from these stories (Bassey, 1999). This was also constructive as stronger relationships were developed with the researcher over the time period. It also strengthened the information which was to be gained from the nurses as between interviews there was an opportunity for them to reflect on previous sessions and for them to bring any thoughts and ideas to the next session.

It is acknowledged that longitudinal studies can be very time consuming and the attrition rate can be high. For this study it was felt that candidate attrition would not be an issue during the data collection period as each interview session had its own theme, and was therefore self-contained. The information sought was the experiences and views on the themes and topics from these nurses as a group, as opposed to the views of a single individual. Furthermore, taking the points of Parahoo (2006) into consideration, the researcher visited the group regularly to conduct interviews, and this allowed the nurses to

become comfortable with the researcher which over time enabled them to be more willing to share their experiences. Therefore it could be argued that the use of a longitudinal study for this cohort of nurses was a valid method to use.

Cases/participants, including sample size and structure

The nurses participating in the second phase interviews (prospective group) were self-selecting for interview. Over the six month data collection period, out of a potential 15 participants, one to five nurses turned up for each of the sessions (table 4.3). All of the nurses were female. The only demographic data collected was that of the nurse's country of origin; Ghana, Zambia, Pakistan, India and the Philippines.

From table 4.3, it can be seen that on two occasions only one person attended a focus group session. As a consequence, it is acknowledged that these two sessions were probably no different to an individual interview where the data generated on the topic area is based on the individual's knowledge and opinion of the subject. Equally, the individuals may have expressed exactly the same views and opinions had there been a focus group session as the question prompts used by the researcher would have been the same. It was therefore felt that using the information received would not adversely skew the research findings. This is because the data from the two sessions would be fed into the development of the questions for the next focus group session and the development of the vignettes. In essence this data would subsequently be 'tested' with other participants to ensure it was representative of their views.

It was the intention when designing the data collection methods for this research, that all of the nurses from the identified cohort attend all of the focus group sessions. This however did not occur for any participant. Table 4.3 shows that some of the respondents attended more than one focus group session, which could potentially lead to a situation whereby the views of one individual is more prominent in the data which is collected. This effect was reduced by the research process of grounded theorising, where the data collected was constantly reviewed and compared in order to identify significant events. These events were then fed back into the next focus group session, in order to establish their validity.

Table 4.3: Demographics of nurses interviewed in prospective group

Interview number	Topic	No of respondents	Country of origin
1	General discussion based on the interview guide for the retrospective group interview guide (appendix 3)	5	Ghana Zambia Pakistan Philippines x 2
2	Differences between home and the UK	1	Ghana
3	The adaptation course and the professional framework	1	Philippines
4	Clinical skills	4	Ghana India x 2 Pakistan
5	Clinical skills <i>Vignette used</i>	5	Philippines x 2 India Ghana Pakistan
6	Communication skills/issues <i>Vignette used</i>	5	Philippines x 3 India x 2

Methods of data collection, interviews and vignettes

The responses from the phase one interviews informed the design of the interview guide (Appendix 5) and vignettes (Appendix 6) used for the second phase of data collection with the prospective group of adaptation nurses.

The use of story-telling using vignettes was a key feature of the second phase interviews and so the interview guide needed to be flexible to accommodate this. It was important that there was a focus on the topics to be explored in the interviews, but crucial that this information be given freely by the participants. This is so the participants could be encouraged by the researcher to talk and give their views about the issues and events that were of significance to them. The overall aim was to generate a rich source of information, based on the nurses' personal experiences and personal points of view. Also there was an emphasis on the importance of understanding events in context, and avoid taking out of context, the nature of what occurred to prevent distortion (Hammersley, 1992).

A vignette is used as stimulus material to encourage participants to discuss their own experiences, although there are different definitions given by different authors as to exactly what they are and how they should be used in research (Angelides et al, 2004; Barter and Renold, 1999). In the main, they are described as being short descriptions or stories of situations produced in a written or pictorial form (Hill, 1997) to which the participants are

asked to react and describe their reactions (Polit and Hungler, 1999). Vignettes allow the researcher to standardise the detail given to the participants of real or hypothetical persons or situations, which contain the necessary information upon which participants can base their judgements (Angelides et al, 2004). This allows participants to give a more vivid account of practice, than generalised questions asked in an interview situation.

For this study, the use of vignettes was an integral and important part of generating data. The reasons why it was felt that they would be helpful, is they are a useful tool both as an ice breaker and making participants feel more at ease and they allow a rapport with the researcher to develop (Barter and Renold, 1999). This was not however the main reason for using them. The main motive for using vignettes was that the participants were from different countries and have different experiences, skills and knowledge gained from many different settings. Given a particular situation, it could be argued that one nurse may view this event completely differently from another nurse who experienced exactly the same scenario. This therefore gives the researcher an opportunity to examine how different people interpret uniform situations (ibid) and adds to the internal reliability of the data collected (called respondent triangulation) as all participants are asked the same questions. Further, the information collected would give a breadth and depth of understanding of the personal and professional issues faced by the nurses that may not have been captured by a structured interview alone.

Another reason for the use of vignettes is that they are viewed as being a less-threatening way to explore potentially sensitive topics for the participants because commenting on a story is less threatening than to comment on a personal experience. It also allows the participant to determine when and how much they contribute their own views of the story and can encourage even the quietest member of the group to voice an opinion (Barter and Renold, 1999). Vignettes are also an economical way of gaining information about how people might behave in situations that would be difficult to observe in every day life. It would obviously be very difficult to observe all of the nurses who were participating in the study undertaking or being involved in all of the scenarios presented in the vignettes.

Angelides et al (2004) argue that different researchers define the term 'vignettes' differently and apply them in different ways. They feel that in essence vignettes can be described as being focused descriptions of a series of events, which are presented in a narrative story-like way. It was this definition which resonated with the researcher. For this study, the ideas, stories and events generated from the initial data collection were analysed

and put into a format of a series of vignettes that consisted of mini-stories. In designing the vignettes attempts were made to ensure that they were not too complex and appeared plausible and real to the participants. They needed to contain enough information for the participant to have an understanding of the situation being depicted and where possible, they would have had personal experience of the situation described, but the scenarios were general enough to allow the participants opportunities to add additional factors.

It would have been easy to generate hypothetical vignettes but there was a danger that the stories and ideas may come across to the research participants as not being authentic and as a consequence the discussions arising may not be as wholehearted than if they were based on real life stories. In achieving a more genuine discussion of the issues, the data will be authentic and the outcomes of the data collection much more robust (ibid).

Preparing the data for analysis

Once the first interview of this second phase had been conducted, analysis of the data generated began. The overall analysis of the data collected for the second phase of the research study focused on using the inductive approach of grounded theory proposed by Glaser and Strauss (1967). This is where ideas are generated from the data and from where it is possible to construct and test hypotheses and theories. Denzin and Lincoln (2008) make it clear that the process of grounded theorising is a continuous process of gathering and analysing data in episodes as it is collected. The process does not occur by collecting data in one episode and analysing it at a single point in time. Grounded Theory works within an inductive framework (Payne and Payne, 2004). This means the inductive framework sees the researcher exploring data which allows them to suggest meanings and explanations, which may allow a theoretical model to evolve. The emphasis is on building a theory, rather than testing pre-conceived theories. This process of continual validation should allow the researcher to make a theoretical statement, which rigorously accounts for the phenomena being studied. This commitment to re-examining data continually in light of new arguments is the basis of grounded theorising (Seale, 2004).

By carefully collecting and analysing narrative data over an extended period of time, the in-depth information gained is a rich source of insights which trigger new questions to emerge and further evidence to be sought. By carrying out the study over a period of time, for the prospective group of students in particular, the aim was to reduce the reactivity of the respondents. It is however acknowledged that human nature being as it is, the probability that distortion can arise because the participants are aware they are

participating in research, cannot be totally eliminated (Hammersley, 1992). If research is carried out over a period of time this reactivity can be reduced, which increases its ecological validity. This means that the generalisability of the findings is increased (ibid) to the infinite population of all cases actual and possible which meet the conditions of the theory proposed, assuming the cases studied are representative of that population. So for this study the aim is to generalise from the findings and apply them to all nurse adaptation programmes.

Ethics

There are problems with being a researcher in one's own organisation, which need to be acknowledged and managed during the research process. The participants must be given information about the amount of time that will be required of them for the study and the researcher must ensure that this does not make an excessive demand on the individual or the organisation and needs to be commensurate with the foreseeable benefits from the study (Dockrell, 1995). The researcher is allowed access into the allegiance and hard-earned trust of participants and this can raise issues such as how does one respond to sensitive information particularly if 'shared' in a focus group situation (Fine and Weis, 2008). Another dilemma is what to do if the participants disclose confidential information? There is a tension between maintaining confidentiality as an ethical researcher and disclosing information which should be reported as a loyal employee of the organisation or as a professional required to adhere to a professional code of conduct (Denzin and Lincoln, 2008).

One way of resolving some of these problems, although it will not eliminate them completely is to ensure that ethical procedures are carefully followed and that prior to the commencement of the study the participants are fully informed and agree as to what will be disclosed about them. This should happen at every stage of the research process (Dockrell, 1995).

All who participate in the research must have an opportunity to read the material before it is published (ibid). They must be allowed to challenge the work and request amendments where it enhances fairness, relevance and accuracy. This should ideally occur at every stage of the proceedings (Scott and Usher, 1999). A decision needs to be made on whether to anonymise the cases in the study. It is acknowledged by Dockrell (1995) that it may be difficult to identify individuals from the cases by doing this, although he warns that where

some case studies rely on providing a substantial amount of information about a limited number of subjects, it may not be possible to disguise the individuals concerned.

The identification of individuals in this study was a possibility. This was because the researcher was known to have only worked in one Hospital Trust in England over the period which the data collection for the research was conducted. The research design clearly identifies the cohorts of nurses involved and identifies them by their home countries. The consent process made it clear that the possibility of them being identified existed. They were reassured that every effort would be made to anonymise the information to prevent this occurring.

The consent information should be given both verbally and in writing via an information sheet. This information should be given in sufficient detail not to overwhelm the participants, but should contain enough detail to inform the potential participants what taking part in the study means for them (Seale, 2004). It should ideally be supported by a written consent form, which details that the participants have been informed about the study, they understand the information will be kept confidential within the limits set, and that they can withdraw at any time (ibid). For this study, a letter inviting the participants to participate in the research was sent (Appendix 1). This was supported by an information sheet (Appendix 2) indicating the nature of the study to the potential participants, and why the study was being undertaken and the intended use of the results, along with the consent form (Appendix 4). Participants were reassured that they were not obliged to join and could withdraw at any time. They were also told that their anonymity would be maintained where possible, although it was made clear that given the nature of the study it was possible that the Hospital Trust would be easily identifiable and therefore there was a small possibility that they could be identified, not necessarily as an individual, but as a group. It was also necessary to make it explicit to the participants that the researcher had her own professional and managerial responsibility to inform their employer or professional body of any information which may be disclosed during the study which breached organisational policy or professional codes of conduct or put patients at risk

The gaining of consent is also not without its own problems. Fine and Weis (2008) explain that there is a tension between being a researcher and developing collaboration between subjects. They say that it is an easy process to gain consent from subjects, but it is a different thing to knowing how much the subjects understand about the consent process. Fine and Weis (ibid) discuss that participants are open to manipulation when they are

signing up to participate in the research particularly if they view it as a procedural matter. To take account of this issue and the other issues discussed above, the consent process and information on the research were reinforced verbally before the commencement of any interview.

Consent to conduct the research in the Hospital Trust was sought and was granted by the Trust Ethics Committee and Director of Nursing. An application for ethics approval from COREC (Central Office for Research Ethics Committee) and NREC (National Research Ethics Committee) was considered (since 2006 known as the National Research Ethics Service). Following discussion with the Trusts research and development office, the current study was felt to fall into the classification of 'service evaluation' (NPSA 2010), and that ethics approval from COREC or NREC was not required.

Reliability and validity

The design of any research study has to address the issues of validity and reliability. For this study, time constraints were to have a bearing on the use of the vignettes and interview guide for the individual and group interviews, meaning they were not rigorously tested for reliability and validity, although every effort had been made to ensure that they were clear and unambiguous.

Reliability

It is acknowledged that applying the concept of reliability to case study research is problematic, particularly when unstructured or semi-structured interviews are used. Bassey (1999) therefore suggests that for case study research, the concept of 'trustworthiness', which can be 'measured', should be used. That is, the reader of the research should ask whether the data sources have been continually used in putting the case together and that issues emerging from the data collected have been continually explored and have been adequately checked with the original source, such as the interview participants themselves.

To achieve this for this study, the most up-to-date draft of the research was readily available to participants, in an agreed place that was secure. The nurses were reminded at each stage of the data collection activity that the information was available and that they should avail themselves of the opportunity to look at it and make any comments and adjustments, which they feel needed to be made. A log of who accessed the information would have been useful but was not kept, although the opportunity to read the work completed was taken up.

Validity

Validity is a term used to judge whether the research accurately describes the phenomenon which it is intended to describe (Bush, 2007).

External validity refers to the extent to which the findings of the study can be generalised to other similar settings or samples (Polit and Hungler, 1999). It would be expected from the proposal of this research, that the external validity of the design may not be totally robust. This is accepted for qualitative research, as Schofield (1989, p93) argues it is the researchers' individual attributes and perspectives that count and '...not producing a standardised set of results that any other careful researcher in the same situation or studying the same issues would have produced'. Also, the qualitative researcher needs to be very careful with questioning the internal validity of their work.

Internal validity is the extent to which the research findings accurately represent the phenomenon under investigation (Bush, 2007). The main source of invalidity in interviews is bias, and careful formulation of questions and interviewer training can help reduce but not totally eliminate this. One way to strengthen the internal validity is to ensure that time and effort is put into interpretation of field notes; to ensure that the way events are interpreted would be interpreted the same way by another researcher and the same conclusions reached. Janesick (1998) argues that when studying human interactions there is no single 'correct' interpretation of these and so internal validity may be difficult to attain. Schofield (1989) acknowledges that to make precise replication a criterion for qualitative work at this level is impracticable, but strongly makes the point that the internal consistency in terms of the plausibility of the way the evidence and conclusions are presented are essential.

A condition to test for the internal validity of statistical studies is the use of measurement validity. This measures the adequacy of the links between concepts and their indicators, that is, trying to prove causality (Seale, 2004). Seale goes on to say that using the methodological approach of grounded theory, which by its very nature makes links between concepts and examples (description and explanation) drawn from the data does test for internal validity. That it does so as a form of measurement validity and to ensure achievement of this Janesick (1998) suggests that one's work must be cross-checked through by a process of member (participant) checks, or where this is not possible, to use an outsider to read field notes and interview transcripts. To meet this criterion participants of this study were offered the opportunity to look at the research as it progressed and to

make any alterations they felt were needed. There was one occasion when this occurred. Three participants from the prospective group were looking through the latest draft of the thesis when the researcher was in the vicinity. There was a lot of laughter coming from the group and on spotting the researcher they launched into picking sections of text that had been derived from the retrospective group interviews and volunteered to share similar tales and scenarios that they had experienced. The researcher did not capture this 'informal' conversation as it was outside of the scope of the initial methodology for this study, although it was arguably a missed opportunity. This 'event' did reinforce to the researcher that what had been written applied to others and not just the groups/interviews where the original information had been captured. It also raised a question in the mind of the researcher that when conducting group interviews in future studies, it may be worth sharing the current findings/draft of the research at the time of the current interviews as a deliberate strategy to stimulate some debate and test for validity.

Hammersley (1992) explores the fact that the definitions in the literature between reliability and validity are ambiguous. He suggests that internal validity refers to the accuracy of the description of the particular case (situation, person, organisation etc.), and external validity to the extent to which that case is representative of some wider population. As well as ensuring the validity and reliability of what is being reported, the researcher will need to ensure that the development and presentation of any arguments on the basis of the research findings are substantive, specific and contestable (Gorard, 2002). That is, there needs to be an explicit warrant in the form of a logical and persuasive argument that links the evidence produced to any conclusions which are drawn.

These definitions are useful for the researcher of this study who is concerned with producing a generalised descriptive account of the participants' case and applying it to a wider population. As described above, for this study every effort was taken to test the interpretations of the data collected with the respondents at regular intervals throughout the study. This increases the accuracy of the description of the case, which can then be applied to the wider population.

It is acknowledged that the time taken to conduct research studies can limit the amount of cross checking of data, which is needed to increase the accuracy of interpretation of the data collected. Further to improve the reliability and validity of research findings, the process of triangulation can be used. Triangulation involves the use of several methods of data collection which allows for cross checking the existence of certain phenomena and the

veracity of individual accounts by collecting data from a number of respondents and different sources and then comparing and contrasting one account with another in order to produce as full and balanced study as possible (Bell, 2005).

To triangulate the research findings and increase the reliability and validity of the information gained from the interviews, it was initially felt for this study that using the adaptation programme curriculum documentation would be helpful for this purpose (methodological triangulation). However in carrying out an initial review of this document, it was found to contain only a timetable and one very detailed document on communication to be used by the students during the course of their studies. Therefore the curriculum document was found not to be suitable as a 'test' for reliability and validity of the research data. The researcher needed an alternative way to strengthen the reliability and validity of the research and felt that the method of respondent triangulation (Bush, 2007), that is asking the same questions of the participants in the prospective group, would satisfy this requirement of validity. It was this, which was to influence the consideration and subsequent reasons for the development of the vignettes for the prospective group interviews.

Generalisability of case study research

There are other reasons for the use of the case study approach, including being able to disprove a general statement made by other researchers. This is because whilst no study can prove something, a single case study can disprove a claim. A case study approach is also supportive of the researcher who has a particular interest in a social unit's unique form, or the researcher wants to begin the process of fresh insights as the beginning of a framework of further detailed study of the case (Bush, 2007). For this study, the researcher is interested in gaining different insights about the group being studied and in particular, their experiences of an adaptation programme and how far it met their professional and cultural needs. It is based on the researcher's own experience of working with and teaching these groups of nurses and being aware of the issues they have faced. This is in addition to having read about the experiences of similar groups of nurses in the literature (for example, Alexis, 2002; Alexis and Chambers, 2003a, 2003b; Campbell, 2001; Daniel et al, 2001; Pilette, 1989; Pross, 2003; Witchell and Osuch, 2002; Witheres and Snowball, 2003).

It is the aim of this study to identify the features, areas of knowledge, issues and contexts, which are unique to this particular group of adaptation nurses and which can be used by the nurses and the researcher's own organisation to inform future adaptation programmes. It

will also acquaint the wider nursing community with new information which arises from this work and could possibly be used as a framework for later research (Stake, 2005). The initial aim of this research was to seek information on how one Hospital Trust managed the experiences of adaptation nurses undergoing an adaptation programme in order to learn from the findings and apply them back to the organisation. As the research progressed it became clear that some generalisations were emerging from the data that could be applied to other hospitals or organisations. It can be argued that generalisation cannot be avoided, as there needs to be interpretation of the work and what it means for both the researcher and the reader (ibid). This is supported by Gomm et al (2000) who discuss ways in which case study researchers can use empirical generalisations to produce general findings. This involves drawing inferences about features of the larger but finite population of the case from the study of a sample drawn from that population. The reason for this is that it is not often possible to collect data from the whole case, as for example it may be too large and so parts of the case are explored and the findings generalised for the whole case.

For this study, only part of the case was studied, that is not all adaptation nurses who made up the population of the case participated in the research. The main aim, (even though not all the nurses in the case were studied) will be to draw some generalisations based on the findings from the nurses who did participate. However, it is recognised that the conventional argument is that case study research cannot be used to make generalisations about a wider population. If this is done, Bell (2005) warns that researchers aiming to draw generalisations from their work must take care not to make generalisations based on insufficient data and claim more than can reasonably be claimed. This can occur because the researcher gathers the information and selects what is or is not reported. This then makes it difficult for an independent person to cross check information. Therefore there is a real danger that what is reported is distorted, or there may be a temptation to generalise from insufficient data. To prevent this happening for this study all of the nurses who participated in the research were given an opportunity at all stages of the writing process to read the material as it was being written and they were allowed to request amendments to ensure accuracy.

Methodological challenges of undertaking this research

The research design of a single case study approach in the researcher's own institution presented a particular challenge. The dilemma was related to the researcher's role in the organisation and needed to be fully thought through prior to the commencement of the recruitment of the nurses to the study. The main problem being that the researcher was a

senior manager in the organisation where the participants worked. Therefore confidence and trust needed to be built between all parties, so that it was acceptable to be honest with the researcher about their educational programme, and experiences, without fear of reprisal should they say anything negative. In addition, given the backgrounds from which the nurses came and given they are very hierarchically aware, they may have felt coerced into participating in the study as a 'senior' staff member had requested this, rather than because they felt that they personally wanted to participate. For both the first phase interviews and the group interviews, the researcher spent time reassuring the potential candidates; both in the initial letter and on first meeting the nurses that participation in the research was totally voluntary and they could leave anytime they wanted without penalty. One nurse during the initial interviews took this option.

Conclusion

One of the aims of this research was to analyse the personal, cultural and professional experiences of overseas nurses completing an adaptation programme in one NHS Hospital Trust. The research design chosen was that of a case study approach, using data derived from group and individual face-to-face interviews using an interview guide and vignettes. The interview guides were used as a tool to prompt participants. The vignettes were tools designed to stimulate debate amongst the participants and were felt to be a much more active way to encourage a spontaneous discussion amongst the group to generate a rich source of data. This was in preference to the researcher having to rely on a set list of questions which needed to be answered, and the inherent danger that this could constrain thoughts and ideas if the focus was too narrow. A great deal of thought was given to the ethical dilemmas which could arise from conducting this research. These were addressed by employing a detailed consent procedure. In addition, at each stage, the report of the findings was shared with the participants in order that they were able to validate what was being written. Validity and reliability are critical for any research study in order for it to be believable, particularly if the researcher wants to make generalisations and produce theories on the basis of the work. The data generated from the interviews was analysed using the inductive method of grounded theory (Glaser and Strauss, 1967), with the aim that some generalisations will be produced. Using these generalisations a model was developed which depicts the findings of the research and is a useful tool which can be used by organisations faced with supporting overseas staff in the workplace. This model is presented in chapter 7.

The next two chapters of this thesis will share the analysis of the data collected and will explore the themes and sub-themes that were generated as a result of the analysis of this data. The discussion will draw on the relevant literature to support a conceptualisation of the findings in relation to the overall theoretical framework of culture, which underpins this research.

CHAPTER 5

HOW WE DO THINGS HERE

Introduction

The next two chapters are reporting on the data that emerged from the methodological approach of grounded theory, which was used to analyse the information gained from the one to one interviews and group interviews. The data obtained will now be presented in a descriptive reporting style (Bassey, 1999). The advantage of this style of reporting is that it allows important aspects of a case to be presented as short descriptive pieces and preserves some of the qualities of narrative writing, by telling a structured chronological story based on the analysis and interpretation of the research findings (ibid). Arguably, the use of the participant's own words in verbatim descriptions will reflect powerfully the real experiences of the nurses (Omeri and Atkins, 2002).

The reporting of the data that had been collected for this study was felt to fall naturally into two groups: the experiences of the professional self and the experiences of the personal self. These are presented as two separate chapters although the inter-relationship between each chapter must not be overlooked, which is made clear when a conceptual model arising from this research is presented in Chapter 7.

Emergent themes

Six themes emerged, three for the professional self and three for the personal self. Each theme has its own associated sub themes and these are outlined in tables 5.1 and 6.1.

This chapter presents the analysed data derived from the interviews conducted for this research study and is supported by relevant literature. The following discussion relates to the themes that emerged and were related to the adaptation nurses' professional self, including their professional responsibilities, education, training and clinical skills and their related sub-themes, all of which are listed below in table 5.1.

Table 5.1 Themes and sub-themes: the professional self

Theme	Sub-themes
1) Professional responsibilities	Sub-theme 1: Acknowledgement of the professional framework
2) Education and Training	Sub-theme 1: Support and understanding during the adaptation programme
	Sub-theme 2: Further professional development
3) Clinical skills	Sub-theme 1: Lack of Recognition of previous skills/experience
	Sub-Theme 2: Challenges with clinical skills

Theme 1: Professional responsibilities

The professional structure for nursing in the UK is very highly regulated. The professional body the Nursing and Midwifery Council (NMC) bases its rules and regulations around statutes of law and gives clear advice and guidelines on the standards of nursing practice, which are expected of every registered nurse working in the UK. The professional accountability and responsibility is clearly laid out in the NMC's publication, 'The Code of Professional Conduct' (NMC 2004b). The importance the NMC attribute to record keeping by nurses is detailed in the NMC publication 'Guidelines for Records and Record Keeping' (NMC 2005b). Thus the importance of professional responsibility and regulation for the profession of nursing is made very clear. This professional regulation of the nursing profession is not a worldwide imperative and so the concept of professional accountability and responsibility based on a code of conduct and professional standards can be a new experience for overseas nurses and in particular the implications of such requirements. This was an important finding of this study.

Sub-theme 1: Acknowledgement of the professional framework

There was clear acknowledgement by the adaptation nurses that British nurses were very much involved in paperwork and that the reasons for this relate to accountability. There was a sense that the issues of professional accountability and documentation were really important and that it was very different in the UK in comparison to working at home. Recognising the importance of this is critical, not only for patient safety, but also to protect the nurse from litigation. Two respondents expressed how documentation is an integral part of British nursing:

'Once you come into the [British] system then you see that everything needs to be written up and everything has its value, that documentation is a very important process in our nursing.... So if my friend [were to come to the UK to work] I would have to tell her, "see you can come to UK, you're most welcome, the work is the same as your working back [home]...., but bear in mind, you will tend to document your things because here the documentation is really very important' (Respondent 4).

Documentation is important in terms of professional accountability and responsibility. The comparisons to what occurs 'at home' in relation to accountability were captured by the following comment:

'At home we have a code of conduct but it is not written down...It is taught during our training and is the dos and don'ts. In the UK we are given the NMC code of conduct' (Group Interview 3).

The professional framework and the law are there to protect everyone, whether a nurse or a patient. For the overseas nurses, understanding what each area means from their own perspective and applying it to their own work is a challenge. There is a lot of information and often very little previous experience that they can draw on of working within such frameworks. This in itself caused some anxiety among the nurses interviewed in this study.

There was a sense that the responsibility of the professional framework, along with other factors, caused stress and was discussed by this nurse:

'[What I found difficult was] the constant stress and fear and I'm sure most of my colleagues face every working day. You get pressure from looking after too many patients, visitors and students. You have to write down all the care you've given you have to fill in charts, notes, and computer files. You have to reflect and keep your personal portfolio. Moreover you work understaffed all the time. Fear comes from no win, no fee, easy way to court as well' (Group interview 5).

The fear of litigation is raised by Winkelmann-Gleed (2006) as causing stress and fear in overseas nurses, as it is not something the nurses experienced from the healthcare system in their own countries. An interesting related issue is raised by Leininger (1994), who reports that nurses are facing legal suits based upon cultural issues, ethnocentric biases and inadequate nursing judgement, based on misunderstandings between patients and staff. This would serve to impress further the fact that care needs to be multicultural in approach and should be documented in a meaningful way, in full partnership with the patient. This is supported by Johnson (1999) who suggests that there are better healthcare outcomes if the patients and healthcare professionals work, learn and communicate together as a 'team' in order to stimulate the development of better care.

Theme 2: Education and Training

The adaptation course was very highly regarded by the participants. This is good news for the organisation, as the comments related not only to the delivery of the curriculum in the classroom, but to the support received in the clinical areas, which is a much harder aspect to measure. As will be seen in this part of the analysis, not all comments were positive and there are some key leaning points for the organisation.

Sub-theme 1: Support and understanding during the adaptation programme

The participants felt the adaptation programme was good and the nurses felt supported during this time. In particular, they valued working with colleagues who were also from overseas:

'The programme was great. We were well supported... I mean there were adaptation nurses from many countries, so we were all mixed, sharing our knowledge of everything. I am very grateful to access this course because we learn so much... and we did not know about the slang, and all these bits, about the cultural bits' (Respondent 4).

This understanding of different cultures is very important. If the mentor and ward manager are prepared to manage and work proactively with nurses from overseas, then it can make a big difference to the experience. Getting the British trained nurses to understand the different ways of working and help overseas nurses to integrate into the new environment, will not only help the overseas nurse integrate more fully into the team, but will help towards the productivity and effectiveness of the team as a whole (Winkelmann-Gleed, 2006). This support and understanding came over as being very important to the nurses in this study. The concept of 'support', whether it was 'help' being freely available, or people caring for their pastoral needs, was very much appreciated by the overseas nurses:

'[The welcome on the ward] was all right. There was one adaptation nurse before me so I did not have any difficulties. They knew about the adaptation, so they know what I am for there for and I did get support from my mentor and from my manager. I was much happy because I get the support, I find myself taking my time, I took 6 months to get my adaptation but never mind, I was well supported' (Respondent 4).

One nurse said that her experience of the support given to her from staff in the clinical area was good and that she only had a problem with one member of staff. However, she acknowledged that the member of staff concerned was the same with all new staff and had not singled her out, which made her feel better. There were some negative comments made by British nurses about their overseas colleagues, which were found to be unhelpful and demonstrated the British nurses' lack of understanding as to what the adaptation course was

all about. There appeared to be some animosity between British nurses and the fact that adaptation nurses had to do some of their adaptation study out of the clinical area:

'If only people would take into consideration that we are individuals and not just to say things for the sake of saying things such as "all adaptation nurses, they have to go off 'again' for their teaching sessions", is not very nice' (Respondent 1).

Even though a manager has agreed to accept adaptation nurses into their team and all that goes with it; including the training programme and having to be released from the clinical area for it, there may not be acceptance by the team, who have to cover for individuals during their study leave. As Winkelmann-Gleed (2006) suggests, it is the relationships between individuals in the work place that can influence the attitudes expressed to those who are studying. In managing diversity in these situations, it is more than about managing cross-cultural issues, but includes managing individuals in the team who have different ambitions and attitudes to work than others.

Sub-theme 2: Further professional development

Nurses in the UK are very fortunate that the nursing profession recognises the importance of professional development. In fact, it is a statutory requirement stipulated by the NMC, that a nurse must be able to demonstrate that they have kept themselves professionally developed and updated; otherwise they cannot re-register and will therefore be unable to practice nursing (NMC 2004a). For some of the adaptation nurses this opportunity to develop was seen as being very important and very much appreciated:

'The opportunities for studying is really good. Study leave is excellent as it is in our working hours. At home it would not happen and it can hold you back, as you have to pay for everything yourself' (Group interview 3).

This finding was also mirrored in the work of Winkelmann-Gleed (2006), who found that investing in individuals is key in motivating them and gaining commitment. This in turn serves to develop their confidence and self worth, but more importantly the nurses will feel psychologically equal, accepted and part of the wider healthcare system. However this support for further education opportunities is not necessarily found elsewhere in the world. For example, Omeri and Attkins (2002), report on overseas nurses who were working in Australia who felt that they were discouraged from pursuing further studies.

Theme 3: Clinical skills

Carrying out clinical skills is an essential part of a nurse's function. How they are performed however, can vary from country to country. Bola et al (2003) describe how

Russian educated nurses working in the USA found difficulties in operating medical equipment. This, they explain was not due to the nurses' inabilities, but arose due to the difference in nursing practice and training between the two countries. They go on to explain that some countries focus on dealing with communicable diseases and acute illnesses, rather than chronic health problems, which is one focus of the US healthcare system. Because of this, some overseas nurses may have experienced a general shortage of equipment, or used different technologies in their own country compared with where they are now working. This means that some tasks would be carried out differently, or not practiced at all, meaning the overseas nurses would have a different knowledge base or skill set to the nurses in the host nation. For example Buchan (2003) found that overseas nurses had a different attitude to pain relief than British nurses. This reflected the fact that there was generally a lack of pain relief medication available 'at home', and so it is a matter of managing not only the nurses' technical skills, but their care philosophies during the adaptation period which need to be taken into account.

Sub-theme 1: Lack of Recognition of previous skills/experience

Some nurses in Winklelmann-Gleeds' (2006) study expressed their frustration when applying to work in the UK, as they subsequently found that their qualification was of no value as the two tier system of nurses (Enrolled Nurses and Registered General Nurses) was abolished in 2000 and this meant they could not work in the UK as a registered nurse. They were therefore only allowed to work as a healthcare support worker, even though they had many years experience of higher level skills including dealing with blood transfusions, wound dressings and helping in the operating theatre. This drop in professional/occupational status was found to be a major stress factor in the study conducted by Ehrenfeld et al (1998) and had important implications for the individual's satisfaction with their new life.

Withers and Snowball (2003) found the Filipino nurses had high expectations that they would continue to carry out what they perceived were routine procedures, such as taking blood gases and feared that they would become deskilled. British colleagues being unaware of the nurses' experience and skills compounded this by treating them as care assistants and so limited them in the tasks they could carry out.

In this study all the nurses were eligible to work in the UK as registered nurses. All had demonstrated that they had the skills and knowledge gained from working in their own country needed to meet the NMC requirements. The findings of this study reflect a similar

picture to that found in the literature, that there is a lack of recognition and acknowledgement by others, of the skills, knowledge and experience that overseas nurses have, and what they can bring to the workplace. The lack of this acknowledgment led to a lot of frustration, which is clearly demonstrated in the comment below:

'Coming to the UK as a nurse means you have to start again. I was a manager at home but here everyone thinks that you know nothing they cannot seem to understand that we know what we are doing it is just done differently here...So for example to take a blood pressure at home we use a sphygmomanometer¹ and a stethoscope, here you use a Dinamap¹. We just need to be shown how to use the machine that's all, but UK nurses take it that because they have to show us something, then we don't understand it' (Group interview 1).

There was a general feeling that there was only a British way of carrying out clinical skills. Papadopoulos et al (1998) support this view, saying that for many years, western healthcare behaviours and medical practices [clinical skills] have been assumed to be superior to other cultures. The focus has been on encouraging practitioners from minority ethnic groups to adopt and adapt to western medical and nursing methods, even though these methods may not be the safest or most effective way of doing something. This issue was explored in Taylor's (2005) study, where the overseas nurses felt that British nurses took the view that if the overseas nurse had not been trained by the British system then the overseas nurse had 'not been trained properly'. It was only when the overseas nurses had completed the same clinical skills courses as UK trained nurses that the issues appear to dissipate.

In this study many of the nurses describe their nurse training 'at home' as being very much like the now redundant British Enrolled Nurse training, which was focused very much on delivering basic nursing care and being very 'hands on'. This could be because several of the nurses in this study were from countries that have a shared colonial history. For example, one nurse in the study was from Ghana, where the healthcare system was originally modelled on the British one (Winkleman-Gleed, 2006). The findings of Moore (1999) and Taylor (2005) were the same as for this study, where the overseas nurses expressed surprise at the number of procedures and clinical skills that would be classed as standard practice 'at home', being classed as specialised in the UK. The carrying out of such tasks as giving intravenous drugs and carrying out male catheterisation was routine practice 'at home', but was subject to extra training in the UK. This made some of the nurses feel as though they were taking a step backwards, rather than using the skills and knowledge they had. This issue was also supported by the findings of the study by Taylor

¹ See glossary (appendix 7) for definition

(ibid), where the nurses from Finland, South Africa and Nigeria described the autonomy they had in their own countries; ordering X-rays, prescribing intravenous fluids and medication and found that they were de-skilled on coming to the UK. This study had similar findings:

'Most of the procedures I could do back home, I could not do them here... They are doctors' procedures... Some procedures I could do I was not allowed because I was not registered, with my past experience most of the skills I had' (Group interview 5).

Taylor (ibid) found some groups of overseas nurses felt that they were trained to be a professional nurse and conducting the activities of venepuncture¹, IV therapy¹ and male catheterisation¹ were 'basic skills'. This is in contrast to British nurses who see these activities as being 'higher level skills' and that 'basic skills' are such activities as the washing of a patient, which is a fundamental part of nursing care. For some overseas nurses, the washing of a patient is viewed as being a role carried out by women in the traditional female role of caring, and therefore not their job:

'[what surprised me] is that a third year qualified nurse can not do some procedures for example medication. In my country after three years of college in nursing, one is expected to do medication, venepuncture, cannulation¹' (Group interview 5).

This study found similar issues identified in Taylor's (ibid) study, which was that overseas nurses felt that in not being able to use their advanced skills it affected the care the patients received:

'At home we cannulate¹ and put up IV fluids before the doctor gets to see the patient. Here [in the UK] we can't and the patients suffer' (Group interview 2).

Whilst training for these 'extended skills' is available to the overseas nurses, the time they had to wait to undertake the training was seen as unreasonable. Many felt this was a missed opportunity by the hospital to utilise their skills fully and so improve patient care:

'IV training and cannulation should be completed during the adaptation period and not left until we are back on the wards as we then have a skills gap. At home we are competent at cannulating and giving IV's so it makes sense to ensure we can carry out these skills here in the UK as quickly as possible. It will also save us being criticised by [UK nurses] as having to have yet more study leave for 'basic' skills' (Group interview 2).

¹ See glossary (appendix 7) for definition

In trying to make some sense of this issue for the overseas nurses, some awareness of how different models of care can vary between cultures needs to be discussed. There is a plethora of information (Andrews, 2008b; Holland and Hogg, 2001; Leininger 2002) as to how to approach a person with a specific nursing need who comes from a specific cultural background. For example, providing culturally sensitive care for people from different cultural groups who express different responses to pain requires different nursing approaches and interventions (Andrews, 2008b).

One notable finding from O'Brien's (2007) research was the distinctive role nurses in the UK played in conducting direct care such as washing and feeding patients. These were seen as being central to the practice of nursing and were valued as an intrinsic part of the nursing role. This was in contrast to nurses from some non-western countries where direct care is delegated to patients' relatives or non-nurses. Therefore the idea of nurses being direct carers tends to be much less and as a consequence they tend to have a high level of technical skill and lack practical experience of direct care.

This difference in the specification of the nurse's role, understandably leads to a mismatch of expectations between overseas nurses and UK nurses. Witchell and Ousch (2002) support this by explaining that for Filipino nurses, the model of care is technical and therapeutic and is based on a medical model of care, whereas for western cultures the approach tends to be holistic based, rather than task based. Therefore it is understandable that the overseas nurses were frustrated by the lack of recognition for their higher level clinical skills, which they felt they had already trained for in their home country and were competent at carrying out.

The focus on a task oriented approach can be clearly seen when looking at the different ways nurse training is carried out around the world. Many nurses have logged a considerable number of hours of clinical experience and skills, supervised by experienced nurses, in order to qualify. For example, to become a qualified nurse in the Philippines, student nurses must have delivered 25 babies un-assisted and have assisted in major surgical procedures. In Nigeria, nurses diagnose and treat such illnesses as malaria, typhoid and cholera (Andrews, 2008b).

It can be seen from the above discussion that the difference in nurse education around the world stems from the prevalent social values of who is expected to deliver specific aspects of care and the values that underpin it, as well as the economic climate such as the availability of medical equipment.

The lack of insight by British nurses as to how highly qualified and experienced some overseas nurses are, some of whom indeed had held senior positions in their own country, was also a key finding in this study and that of Cook (1998). The examples above show how problems can occur when there is a mis-match between the professional framework, the curriculum and an individual's abilities. For adaptation courses, the NMC require a standard at the same level as for a nurse newly qualifying in the UK and the curriculum sets out what skills need to be performed to achieve this. The adaptation nurses have to 'prove' they are able to do set tasks and conduct set skills for their mentors to 'sign off' to say they are competent. Therefore, the adaptation nurses have to repeat the clinical procedures they feel competent in performing, and in some cases they may be more experienced than their mentor, just to allow the paperwork to be signed off to enable them to be registered as a nurse in the UK. It is little wonder the process feels overly bureaucratic and the adaptation nurses feel frustrated. There is however, another side to the argument, in that the process serves well to protect the overseas nurse and the patients in their care, by ensuring that the overseas nurse is aware of the impact of UK legislation and Trust policies on the skills they know well. This is arguably a subtle but important point that can be overlooked. There are many skills carried out routinely by overseas nurses that are classed as advanced skills in the UK, for example giving intravenous antibiotics. To undertake these advanced skills, there is a requirement that nurses wishing to carry them out must undergo extra training, as the standard to which they must be performed is that of the competence of a qualified doctor (Tingle, 2002). Ensuring that the overseas nurses undergo specialist training and prove their skills, will serve to protect them (in a legal sense) should anything ever go wrong. It can also be used to demonstrate to the host institution that they are able to execute skills to the required standard.

Having highly developed skills, even if not recognised by others, was seen by some nurses as being an advantage to them:

'I was very quick [completing the adaptation course] because with the twenty years' experience you have done it before. It is only because they want to see that you can do it. So I finished that book in less than three months. Because the NMC's requirements are that it has to be three months, so she [my mentor] signed me off after three months...back home I was already a manager...I have had to start again' (Respondent 1).

The nurses expressed the advice they would give to friends and colleagues who were thinking of embarking on a journey to work in the UK, which would be not to forget home and the skills and knowledge that they have, but to look at the experience as a challenge

and not be afraid to ask questions if they are unsure about anything. Overall from this study it was clear that the nurses who were interviewed felt that their previous experiences as nurses did not count for anything. One nurse in this study explains how she deals with these issues and gives advice to others:

'What I would say to those nurses [coming to the UK for the first time] is, you are coming from Africa or wherever, try and be an ambassador for your country, because most of the people when they come here they think you don't know anything, because you are coming from a third world country. But, if you come as an ambassador for your country and you come with a straight mind that I am coming here to work as a nurse and I hope to show these people what I know and what I don't know and the things that I don't know they will show me, and for the things that I do know I will ask them if that is the way they do them here?'
(Respondent 1).

Overall the lack of recognition for the clinical skills that the overseas nurses have was a source of frustration for them. However, it is essential that no matter what skills a nurse has, they need to make sure that they are working within the set policies and guidelines of the institution they are working in order to protect themselves and their patients from inadvertent harm due to ignorance of current procedures. In consequence, a balance between the two needs to be found within the adaptation nursing curriculum to reduce this gap.

Sub-Theme 2: Challenges with clinical skills

Attitudes of others can have a huge effect on how the overseas nurse integrates into the workplace. At face value it could be argued that nursing is carried out the same way wherever you are in the world:

'I feel I had no problems; nursing is universal' (Group interview 5).

This study found that the 'how' to nurse was the same for all nurses wherever they originated in the world. For example, blanket baths¹ and observations of blood pressure were all carried out using the same techniques. What did differ were the approaches to carrying out the skills and the rules that needed to be adhered to:

'I think I don't have a problem with clinical skills. When I first came to the UK I was familiar with the routines in my area where I work and some equipment... only some adjustments needed to be learned in the first few months regarding the policies in the unit' (Group interview 5).

¹ See glossary (appendix 7) for definition

What these nurses say is critical in understanding how it feels for an overseas nurse to be faced with different policies being applied to a skill they are quite comfortable in executing only because that is the UK rules on how conduct these skills are different from home. This nurse described this phenomenon very nicely:

'People do not appreciate that you do not know quite 'how' to do something. For example I was doing a [urinary] catheterisation, I got the catheter, saline, syringe etc together as a 'pick and mix' approach and find I get laughed at by UK nurses as there is a ready made pack available with all these things in' (Group interview 4).

Winklemann-Gleed (2006) says that positive attitudes shown towards overseas nurses when carrying out clinical skills can greatly ease their integration. By taking time to explain procedures to nurses, which may be executed differently from that experienced in their home country and by explaining exactly how equipment works, the overseas nurses will be greatly helped. This gesture will enhance the belief in the overseas nurse that the home country nurse has accepted them and that they are being fully supported in adapting to British nursing. In this study the overseas nurses were very aware that they had a skills gap;

'Use of new technology and machines needs more training on how to use them or at least show us how to use them' (Group interview 5).

The nurses in this study were very determined to address their skills gap. It was very clear that the input and support from the British nurses who understood or tried to understand what the nurses were experiencing, was very important to them.

'Everything found to be easy we were never left on our own. There was always somebody to show us things that we were not quite sure of' (Group interview 5).

Winklemann-Gleed (2006) suggests that the host country nurses can make a huge positive impact on the experience and confidence of overseas nurses. By having a genuine interest in the past experiences of the overseas nurse and learning from them how things are done elsewhere in the world, demonstrates respect for that nurse's previous experience. Host country nurses who can present themselves to the overseas nurses in an approachable manner will allow the overseas nurse to be confident in asking for help without feeling inferior and/or intimidated:

'We don't have training at home in using medical equipment, as we do not have such equipment. Here you have careflow meters¹ for NG feeding¹. At home we use

gravity...we do not have tourniquets¹ ...we cut up a piece of an IV line and use that – we improvise’ (Group interview 4).

The adaptation nurses also had some views as to British nursing and how it varied to home:

‘Back home we are more involved, like patient wise. They’ll walk around with the patient; they try to be with the patient but not most of the time because they have their paper bits to do... but back home we were there giving the help to the patient’ (Respondent 4).

Conclusion

This chapter has presented the personal professional issues with which the overseas nurses were confronted during their adaptation programme. These included their professional responsibilities and the impact on them of the professional framework. It explores the education and training the nurses underwent during their adaptation course and the support they were given during this period. This is very closely related to the theme of clinical skills and the sub-themes of the lack of recognition of the nurses previous skills and knowledge and the challenges with clinical skills working in a new environment.

Professional regulation by the NMC is an integral part of British nursing. The NMC sets the standards by which every Nurse and Midwife in the UK needs to practice. Very few countries in the world have a professional body for nursing and consequently this was a new concept for the nurses in this study. The nurses found that they had to change the way they were used to working and, in particular, there was a need for them to document all aspects of the care tasks they undertook. This they recognised was driven by the fear of litigation, which they would not have experienced in their home country.

Overall the nurses in this study enjoyed their adaptation course and they felt supported by their mentors and managers. Some overseas nurses reported that they felt there was some animosity towards them from other registered nurses because they had to leave the clinical area to attend study days, which may have been a reflection of the lack of knowledge by the British nurses as to what the adaptation course entailed. Following their adaptation programme the adaptation nurses were very grateful to be able to access further professional development opportunities as they did not have these opportunities at home.

There is no doubt that overseas nurses are a valuable asset in the nursing labour market and many are very talented and have significant experiences in aspects of nursing never seen, let alone experienced, by British nurses. This study supports the work of Baj (1997), where some of the overseas nurses lacked experience with technological advanced medical

equipment, but they were mature and experienced which helped them overcome such obstacles. These differences stem from the models of care advocated in the nursing programme of each country which is driven by the prevalent social values and economic climate. A key finding of this study so far is that there is a general lack of recognition of the skills and experiences of the overseas nurse by British trained nurses. This lack of recognition caused upset as it was felt that no value was placed on what the overseas nurses had to offer, which devalued their sense of professional worth and thus their confidence in the workplace was affected.

From the 'tone' of the response from the overseas nurses in this study there would appear not to be any resentment as to the way that they felt they had been treated. There was clearly a sense of frustration that they were not allowed to get on and do the job they were already trained to do and capable of doing. In part this was due to the different professional and legal rules that are applicable to working in the UK as a registered nurse. As a consequence, 'extra' training for skills the overseas nurse already possessed was required. As already stated another factor that upset the overseas nurses were the negative views and lack of recognition by British trained nurses of the skills and experiences the adaptation nurse held. The rationale for these perceptions was not explored in this study but they appear to be multifaceted and would be worthy of further study. What is clear from this study is that most overseas nurses are competent at conducting all of the skills required; they just need some guidance in 'how we do things here'.

Having explored the professional issues that the overseas nurses faced during their adaptation programme, the data gathered from this research study also revealed that there were personal issues that the nurses had to deal with by coming to work in the UK as a nurse and these are discussed in the next chapter.

CHAPTER 6

THE BRITISH LIKE TO DRINK LOTS OF TEA

Introduction

This chapter will explore the personal issues of communication, culture and attitudes experienced by the adaptation nurses as described in Table 6.1. Whilst it is acknowledged these experiences occurred in the workplace and in a professional context, the individual nurses experienced their effects and responded to these personally, which then had a bearing on their professional role. It is therefore the personal experiences of the nurses and how they dealt with them, which is the focus of this chapter.

When deciding to leave home and work abroad, it is not only about adapting your professional knowledge, skill and experiences of being a nurse which was the focus of Chapter 5. There are also personal adaptations that need to be made. Working with a new team of people in a new working environment, where the way work is conducted is very different from home can be challenging. The different language and communication methods can exacerbate this further, compounded by the different cultural norms used in the new environment.

Table 6.1 Themes and sub-themes: the personal self

Theme	Sub-themes
4) Language and communication	Sub-theme 1: Understanding of the English language
	Sub-theme 2: Own communication skills
5) Expectations and understanding of own and other cultures	Sub-theme 1: Nursing patients from different backgrounds
	Sub-theme 2: Politeness and respect
6) Attitudes experienced by overseas nurses when working in the clinical area	Sub-theme 1: perceptions of the overseas nurses and the negative attitudes they experienced

Theme 4: Language and communication

As discussed in the literature (Campbell, 2001; Leifer, 2002; Witchell and Osuch, 2002), the need for adaptation nurses to learn local dialects and slang is important for them not only to be able to carry out their duties as a nurse, but for them to be able to manage

socially. In the research reported here, there was an acknowledgement by some of the nurses, that their own communication skills could be a barrier.

Sub-theme 1: Understanding of the English language

Buchan (2003) found in his study, that whilst overseas nurses were technically very proficient in speaking English, they had difficulty in writing or comprehending English or could not understand local accents or colloquialisms. This was also a finding of this study, with the nurses offering the following:

'Accents and words not used in standard English which are finding their way into English was a problem. I had to learn some of these words' (Group interview 6).

Some misunderstandings arose because the first language of the nurse was not English and this, in turn, had far reaching effects on some of the nurses. Clarity of speech was an issue that the nurses reported and was related to accents or the delivery of the verbal message:

'Some people they talk better English. For example if I listen to the radio or when I look at the news, they are quite clear, very clear to understand' (Respondent 5).

Other issues associated with others' use of idiomatic language were challenging for the adaptation nurses;

'Language is hard such as 'she only needs a 'cats lick' ' (Group interview 5).

Verbal language not carried out in a face-to-face situation, such as a telephone conversation, can put up further barriers for the overseas nurses as they are not able to rely on non-verbal communication to help them understand the context of the conversation. A study by Magnusdottir (2005) found that participants said they experienced profuse sweating and rapid heartbeat when they were asked to answer the telephone and it took a long time for them to become comfortable in so doing. For this study conversing on the telephone was found by some to be very difficult:

'The language barrier was the hardest for me I would avoid all telephone calls' (Group interview 4).

Whenever possible the overseas nurses should feel comfortable in asking the other person to repeat themselves but this is not always easy or even possible:

'Handovers can be very difficult particularly when the handover is taped. Some nurses do not speak very clearly into the tape and it is hard to understand what they are saying' (Group interview 1).

Winkelmann-Gleed (2006) suggests that when English is acquired as a second language there are difficulties with comprehension of humour which is culture bound. Sarcasm or irony are common elements of English humour, and are often puzzling for people from overseas as they do not translate very well and can be offensive to individuals. This can be demonstrated in this study from the comments by these nurses:

'Colloquial language at first I found difficult as it did not make sense to me and my mentor thank God, was there for me to interpret the meanings. For example I said to one patient "I'm going to give you a small prick" and she went red' (Group interview 6).

It would appear that understanding English with its different dialects can make the understanding of what is being said very difficult for overseas nurses and feels more or less as if they have to learn a whole new language. This is certainly something which needs to be taken into account by curriculum planners when developing adaptation courses and by nurses who will be supporting overseas nurses in the clinical area.

Sub-theme 2: Own communication skills

For many nurses it can be difficult to understand the cultures of others, whether work colleagues or patients. Likewise, how others interpret an overseas nurse's culture and ways of communicating raises some interesting issues as this example conveys:

'Some people probably think I am "rude" and "bossy" because I don't use "sorry", "thank-you", "would you be so kind..." as often. I try to make sure people around me understand that I am doing my best to remember the right way of asking but I just forget sometimes. It's not natural to me, it's not part of my culture and often under pressure I forget, but don't mean to be offensive' (Interview 6).

There needs to be some understanding by nurses that their work colleagues and patients from different cultural backgrounds may have different ways of expressing themselves and relationships can be affected by this lack of knowledge and understanding. When the communication style demonstrated differs from the established norm of the host country it can be interpreted as being inattentive, subservient or disrespectful, which is not usually the intention of the action (Bola et al, 2003). For example, Sugirtharjah (1994) explains, the notions of respect in Asian traditions means that polite forms of expression are built into the sentence structure and it is not common to say 'please' or 'thank you'. The word 'boy' in European cultures means male gender; in Black and African cultures, it is a derogatory expression (Burner et al, 1990).

As Gerrish et al (1996) point out; culture, anxiety and awkwardness can make communication styles formal and stilted and open to interpretation of being negative or hostile. Not understanding these issues can lead to negative attitudes towards individuals, which can compound stereotypical beliefs. Giger and Davidhizar (2008) say that Filipino Americans tend to use tone of voice to emote or romanticize the language, and they may get loud in the presence of family members or if they are nervous or frightened, which is in strong contrast to their normal style of being very softly spoken. In fact, the nurses in Magnusdottir's (2005) study said that it came as a real shock to find they could not fully understand the language being spoken around them and be able to respond in an effective way. This they felt impaired their ability to give good nursing care and their sense of professionalism suffered. They used metaphors to explain how they felt such as '[It's] like when you are underwater. You speak but only...bubbles...come to the surface...you are mute and you are like deaf. All your words are like blocked inside you' (Magnusdottir, 2005, p267).

This gave the nurses an overwhelming sense of anxiety and insecurity, because they felt they might cause offence or hurt someone just because they said something wrong. These feelings were echoed in Scholes and Moores' (2000) study, where the British nurses working abroad explain that although they recognised words, due to accent and dialect, the meaning of those words was unclear. This in turn caused the nurses to stop and consider the meaning of every communication on which they were about to embark. One nurse describes the frustration of how a simple sentence took minutes to formulate and ten to explain. As Bola et al (2003) point out, lack of communication skills can hinder overseas nurses from carrying out their professional roles and responsibilities and can lead to delays in patient care being delivered, or worse, could put a patient at risk of harm. They go on to say that even if the nurse is very knowledgeable, the language barrier can cause high anxiety and in emergency situations, the additional time needed for mental translation, adds to this risk of harm and can diminish the nurse's credibility in the eyes of co-workers. This can set up further barriers between the nurses.

In this study one nurse had knowledge and skills of other languages and saw this as good thing as she felt her knowledge of speaking several languages was recognized by others and was looked at in a very positive light:

'I can speak five languages ...and we get many patients here who do not speak English and I think that is why I am still on Ward [X]' (Respondent 3).

This talent for speaking and being able to work with many ethnic groups can also be seen as a disadvantage, as non-minority group nurses/healthcare professionals can take advantage of the nurse who is comfortable with several languages and cultures, sidelining them in to doing interpreting work in the clinical area at the expense of carrying out the normal complement of nursing skills and duties (Gerrish et al, 1996). This is supported by Culley (2001) who also feels that it is a good thing, as nurses with languages from different minority backgrounds will be of benefit to the organisation. However, Culley also warns that if it is not managed well, the nurses will fill the gaps where the organisation fails to develop appropriate services for minority groups. This could include organisations using nurses inappropriately to translate for patients, rather than pay for interpreters, thus undermining their role as a nurse. However some organisations do this deliberately (Baj, 1997) as a way of the overseas nurses paying back the incidental costs of their employment by offering their interpreting services free.

What has become clear from this and other studies is that, no matter where in the world a nurse has originated and where they choose to work, language problems are inevitable. This is because they have to process cognitively the information they have received in English and then translate it mentally into their own language. The next stage is for that content to be conceptualised and their understanding of this new material is then re-translated back into English (Wilson, 2002). It is therefore important that language and language skills are addressed and this needs to be given strong consideration in any adaptation programme. However, Davidhizar et al (1998) warn that educators being involved in developing such programmes should be cautious in their approach not to generalise that certain communication patterns belong to all people from a particular cultural group, as this is often not the case.

Theme 5: Expectations and Understanding of own and other cultures

Different cultures have different values and norms which dictate how people behave towards one and other. Nursing is no different, having its own professional and social culture which is learned during nurse training and practicing as a nurse (Holland and Hogg, 2001). This is based on the nurse's own ideas about health and illness which have been shaped by the nurse's ethnic and cultural backgrounds (ibid). These cultural 'rules' must be obeyed in order for the nurse to survive in the profession. For example British nursing has its own language which may be alien to others, such as 'doing the obs'¹, or 'doing the backs'¹ which may not be the same terminology used by nurses from other cultures

¹ See glossary (appendix 7) for definition

(Holland and Hogg, 2001). De Santis (1994) feels that for nursing practice, there are three cultures that arise when nurses meet patients;

The nurse's own professional culture, with its beliefs, values and practices.

The patient's culture based on the patient's life experiences of health and illness and their personal values, beliefs and practices.

The culture of the setting in which they meet (e.g. hospital, community or family setting).

By understanding that these cultural differences exist, this can help the nurse understand some of the actual and potential problems that could occur when delivering care. This is supported by Johnson (1999) who suggests that reflexivity and communication can only be improved if the differences between groups are seen as not being a problem but as an opportunity to stimulate the development of better care. It is therefore important that the overseas nurse is personally prepared for working with patients from other cultures. If they do not have awareness or an appreciation of others' cultural norms this can impinge on their professional role and the care they deliver to their patients. Likewise they need to be aware of how their own cultural values can affect others. It is this personal knowledge of different cultures and the execution of this by each adaptation nurse that will affect the care they give to patients and the responses to that care which they will get back.

Sub-theme 1: Nursing patients from different backgrounds

There was acknowledgement that there were cultural issues to which the adaptation nurses themselves had to adjust during their time in the UK and this was not just from the British way of life and ways of working, but also how to deal with others from other ethnic groups. One nurse describes an observation made of the interaction between Indian nurses and Indian patients:

'Different castes have issues with other castes' (Group interview 4).

This Holland and Hogg (2001) suggest may occur because of the structures in Indian society. For example, the touching of excreta is linked to low status and belonging to a low caste. They go on to say that it is important that nurses need to ensure that nurses of all cultures understand their role in order to prevent any misunderstandings, which could make it difficult for them to carry out their role effectively. In this study the nurses were aware of the differences in attitudes shown by different cultural groups as the following respondent says:

'Coming to Britain is mostly cultural, you need to know the culture and when we are doing our adaptation course we need to learn how to handle the Asian people' ... 'What was really surprising was the Arabian people, I thought they would be friendly, but they weren't' (Respondent 1).

This comment about the 'Arabian people' was interesting. It could be argued that this is an example of how another culture may not have been fully understood by the nurse. To label and produce stereotypes of people who come from different countries in the middle east and label them as one homogeneous group called 'Arabian' can be as misleading as labelling and stereotyping all people who live in European countries as being 'Western' and assuming they all have the same cultural values and communication styles. There have been many authors who have tried to classify the cultures of the world and suggest what the approximate values of people in a particular culture will be. However, this is very difficult to do as one cannot predict what any one individual's values will be and equally not everyone in a particular culture believes or behaves in the same way. Sometimes, there is greater variation within single cultures than across cultures (Treven et al, 2008).

The research conducted by Al-Hamdan (2009) supports this view. He found in his study that nurse managers from Oman had a tendency towards a more domineering collectivist style which is reflective of a society that has high power differentials and as a consequence Omanis are very careful about what they say and to whom. The situation and age of the individual can also had a significant effect on the way they respond to others and can be indicative of their desire to accommodate their peers and supervisors. These findings were in slight contrast to the Jordanian nurses who demonstrated that they are much more compromising in their style, preferring to focus on the practical aspects of care giving and have a moderate concern for people. This "style" requires an intermediate level of both assertiveness and cooperation (ibid). This therefore demonstrates that there are differences within cultures, such as 'Arab' cultures, where sub-cultures prevail.

Individuals can also hold different views of the role of the nurse and nursing depending on a person's country of origin and their culture. In some countries in the world, nursing is seen as a low-status occupation where caring for the bodily needs of the sick is considered unacceptable and that nursing is the most undignified of all occupations, and is for lower class workers (Andrews, 2008b). In contrast, nurses who have trained in countries such as Ghana, have a different social status, as nursing is viewed as a prestigious profession and is an occupation with status. Nursing uniform is worn publicly at events such as weddings and is done so with pride (Winklelmann-Gleed, 2006).

It would therefore appear that there is a need for overseas nurses to be given information on other cultures, and not just British culture, to help them in their role as a nurse working in the UK:

'Back home we did not have people of multi-cultural [backgrounds]... I mean, our cultural needs from back home won't be helpful here, at least we have the communication skill and we speak English. In terms of when I was dealing with patients on the ward then trying to seek out their cultural bit, was, I felt not that easy, to understand what they wanted to do' (Respondent 4).

Likewise, there is a need for British nurses to have cross-cultural knowledge in order to meet the needs of patients and staff from minority groups:

'There were both of us from Africa, there was somebody who treated us the same but I had to say [to her] even though we are from Africa, we are different from each other... Some are similar, but some aren't [in terms of background and beliefs]' (Respondent 2).

It is clear from the study conducted by Gerrish et al (1996) that many practitioners are not adequately equipped to provide appropriate inter-cultural care to minority ethnic patients. This can only be addressed, if it is acknowledged by nursing educational establishments that this is a subject which needs to be integrated into the nurse curriculum. This would go some of the way to alleviate, although not always solve, some of the differences in expectation from a nurse and patient perspective on nursing and medical duties and actions. Papadopoulos et al (1998) suggest that cultural knowledge and awareness are important to enable healthcare professionals deliver sensitive and appropriate care and to try and give patient real choices and avoid oppressive practices. However Andrews (2008a) does warn that understanding others' cultures is not enough to eradicate ethnic or cultural conflicts and dilemmas. The only way this can truly be achieved is by nursing students and others having positive experiences with members of other cultures, in order to understand and show tolerance and respect for the diversity of others. Some of these differences can be quite challenging for the individual patient and if not fully understood by the nurse can cause some conflict and upset as this example shows;

'In my culture if a patient prefers to be seen by a female or male doctor, it would happen. It's like [here in the UK] you have to be seen by every doctor, you don't have a choice here...' (Respondent 1).

This comment is very similar to that found by Gerrish et al (1996) in their research study where they found there was a strong cultural expectation around the notions of decency and privacy, related to body management. In particular, women from many different

backgrounds felt they were offered very little in the way of privacy and felt they were given little choice in the gender of the healthcare worker delivering their care. The patients found this difficult to cope with.

'[I had an issue with culture] just once when I was on my former ward, they don't want a female to look after the men it is expected that only their wives [the only female] are allowed to do this...but I have not really had any nasty experiences with anybody' (Respondent 1).

Gerrish and Griffiths (2004) say that religion does restrict females coming into contact with males, other than immediate family members. However, this 'rule' is not enforced when looking after sick people. Holland and Hogg (2001) say that a male patient being cared for by a female nurse from his own cultural and religious background can be helpful in terms of the nurse being able to understand his communication and cultural needs but it can also be problematic. For example, in Muslim culture the relationship between men and women is very restricted and for a male to be cared for by a female Muslim nurse may be more embarrassing than if he were being cared for by a female non-Muslim nurse.

There are also the needs of the relatives to consider when caring for their sick relation as the role the relatives play in looking after the sick family member does vary from culture to culture. Relatives can be difficult to manage whichever culture they come from, but nurses do try to understand the reasons for this;

'Some relatives could be very difficult to handle but it is understandable when your relative is sick, one wants the best to be done' (Group interview 6).

Individual behaviours and responses can also stem from learned cultural behaviours. In some cultures, there are sick role behaviours (Andrews, 2008a), which are taught and learned and can manifest themselves in many ways, including, asking too many questions, assuming a defensive posture, being aggressive and demanding, or being very quiet and compliant. Different cultural groups will respond in their own way and it is important that the healthcare professional is aware of this, so that offence is not taken, or situations misread. It is therefore really important that the nurses understand the role they play. Andrews (ibid) suggests that a 'role' is an expectation of the behaviour associated with a specific position. If that role expectation is not made clear then this can cause both intrapersonal and interpersonal conflicts which could have been avoided. What follows is the nurse describing the way care is delivered in the UK compared to home:

' [Things are different] ...such as the nursing here, because people have relatives as well in the wards [at home] here it is not the case, which was a bit different for me, because we can't get the permissions from the relatives. Here we do what has to be done and have to rely on the history, to fully treat the patient on our own, not with the relatives. So that was a different way of working for me' (Respondent 3).

This is an interesting insight into patient care overseas, and the expectations of the role of relatives. Clearly the relatives were seen as important people in the patient's life and are heavily involved in the care planning and care delivery for that person. This is something, which is not really advocated in the UK except possibly for children or patients with special needs. Indeed, Holland and Hogg (2001) say that in Western cultures, great importance is put on maintaining privacy and respecting confidentiality of the patient's medical condition and that the care they receive is very much patient-centred. In Eastern cultures the patient may be seen in the context of the whole family and an illness can be viewed as a crisis for the whole family. There are also different views as to the role of the family when a member of the family is ill. In Eastern cultures there are practical issues to be considered when caring for a sick relative. For example the provision of health care in the hospitals may be poor and so relatives are expected to deliver that care. There may be a notion of leaving an ill relative alone in hospital may seem neglectful or even abusive (ibid), and was a concept supported by this nurse:

'At home, relatives come into hospital in the morning to wash their relatives and look after them, it does not happen here...as a family you all pull together to ensure your [ill] family member is looked after. Someone is given the job of doing the caring and everyone else has to support that person' (Group interview 1).

Dealing with these differences and knowing what to expect is difficult. Trying to prepare nurses for what may or may not happen is not easy, as everyday life is complicated and the variety of issues that can arise are endless. This is nicely illustrated by the following two examples:

'Family problems can be difficult in the UK. I remember a [British] family arguing about who could feed the mother and who couldn't and it involved a lot of nursing time trying to sort the issue out. In India, regardless of whether there were family issues, they would look after the mother as a family. The nurses [on the ward] would never know there was a family problem' (Group interview 5).

'Handling the relatives when a patient had died was different to what I was used to. At home the relatives really grieve, they wail and roll about on the floor, here everything was very restrained. The first time I had to deal with it [the death of a patient] I left the relatives alone. Afterward my colleague said to me, you did not make them any tea, I explained that I did not know that I had to...now I know that they need lots of cup of tea' (Group interview 1).

The 'handling' of bereavement can manifest itself in many ways depending on the culture to which the person belongs. For example, when a Hindu person dies the older women in the family will mourn in the traditional manner by wailing loudly to show their grief (Holland and Hogg, 2001). Also, in such circumstances men do not project a stoic demeanour but can be just as expressive as the women (Giger and Davidhizar, 2008). What was interesting from the above quote was the stereotypical image by the overseas nurses that the British like to drink lots of tea in circumstances such as bereavement. This arguably is a valid stereotype derived from the traditional belief by the British that tea is an essential remedy for all social and psychological ills, from a bruised ego to the trauma of a divorce or bereavement. This is possibly derived from the fact that tea-making is the perfect displacement activity and whenever the British feel awkward or uncomfortable in a social situation they postpone the uncomfortable bit by making sure everyone has tea (Fox, 2005).

Whatever the differences in culture between a nurse and a patient, the nurse who is able to respect the patient's traditional cultural values and beliefs, whilst considering the professional needs that will be of benefit to the patient, will be the nurse who delivers meaningful and culturally congruent care (Leininger, 2000). Managing the expectations and understanding of different cultures requires diversity management to become an integral part of the workplace. Winkelmann-Gleed (2006) stress that this cannot be taught fully in study days alone and requires an open and honest discussion about such issues outside of the classroom. They suggest that a two-way communication and learning process is set up in order that students can share cross-cultural concerns and policies. That is they need to be encouraged to learn from each other and by opening up to others as well as try to understand and support others. This requires the nurse to be able to step out from their own frameworks and views of the world and try to perceive the situation from the patient's point of view, in order to develop plans of care that have been mutually agreed (De Santis, 1991). Nurses need to be willing to do this and be open and receptive to put into practice what they have learned.

Sub-theme 2: Politeness and respect

There were some acts carried out by overseas nurses, as a mark of politeness and respect, which they felt was not understood by the British.

'At home once you walk into a place, you say "morning" to everyone and people would respond. It was different here...like where I come from, you wait for a bus

and you talk to everybody, even strangers, in fact where I come from, because you are standing next to a person you have to talk to that person' (Respondent 1).

This is part of the way we have been 'programmed' by our society and culture and our decision to accept this "programming" as the correct way to act in a given situation. Usoro and Kuofie (2006) cite an example of a Nigerian woman, who, on arrival in the UK, would find it unwelcoming to be asked how long she is staying in the UK. The enquirer is asking this as a friendly question and a friendly gesture, out of interest. In Nigerian culture, it is taboo to ask visitors, who often turn up without any notice, how long they are staying. To do so would mean you are asking the guest to leave immediately. In this study the overseas nurses had had an expectation that others would be friendly but found that this was not always the case:

'... [British] people not really as forward... because you meet somebody, she smiles at you, if she doesn't really smile we call it like "for show" and you know that she does not mean it [to smile] and that is not nice' (Respondent 2).

The lack of 'respect' shown by British nurses to others was found by Cook (1998) in her study of overseas nurses' experiences and the participants in this research study also found it surprising:

'The respect things is hard... at home you never call anyone older than you by their first name, you have to use a title such as "Miss Julie", not to do so is disrespectful and it takes a lot of getting used to [when working in the UK]. This happens both at home and in nursing when you are looking after patients' (Group interview 1).

Magnusdottir (2005) found that initially the nurses were uncomfortable with the informality of using first names but with time they had grown to like it. Understanding this cultural difference is important and can be significant when delivering patient care. It needs careful consideration by the nurses who have come to work in the UK, as they have to consider the impact of this on working in the UK and how it could affect them later, when they return home as this respondent points out;

'Another thing was calling patients by their first names [at home] it was a bit difficult to do this, but we prepared from the classroom... after a while I became used to it. And it's like, that is the culture, and nobody feels hurt when I call their name, "John" or "Jim", they are happy about it. But when I go home I will find it difficult [to re-adjust to using only a patients surname]' (Respondent 2).

Papadopoulos et al (1998) puts this into context from a patient's perspective, saying that many different cultures use different conventions to show respect and that healthcare professionals should make every effort to try and ascertain the preferences of each

individual patient, as it is critical for their identity. Not doing this can make the patient feel the same way we do if someone shortens our name when we prefer the full version, spelling our name wrongly, forgetting our name or using a form that we do not like. Overall, it is good practice to ascertain these preferences, no matter from where in the world the patient originates.

Nursing overseas can be seen to be very hierarchical (Lee, 2004) and people from eastern cultures are often brought up in a style which respects authority and the individual demonstrates respect for their supervisors and elders (Al-Hamdan, 2009). The findings of this study would support this view, that the presence of a hierarchy plays an important part of the normal cultural rules of many overseas nurses and the apparent lack of this in the UK was a significant deviation from that with which the nurses were familiar. For example, in Asian traditions, the term 'respect' has more than a formal connotation (Sugirtharjah, 1994), it refers to duties and obligations to the family and community and to the conduct and behaviour which is expected and this is very closely linked to respecting the hierarchy which is in place. From the following examples the difficulties and tensions can be seen clearly:

'Patients are called by their first name, which I find very difficult. At home we call them "sir", "madam" to show respect. So a young person but in a senior post you call them "sister" followed by first or surname. The first name is preferable on where they are in the hierarchy and your relationship with them. Older person and senior you call them "Sister" Young person who is junior you call them by their first name. If this is a Doctor you call them "Sir", "Madam" (Group Interview 5).

'You stand for the Doctor or Senior Nurse if they appear whether this is in the office, coffee room although in Indian culture you would not stand up in front of food such as the canteen/dining room' (Group interview 5).

This 'respect' shown by overseas nurses can pose problems for them in an environment where this is not practiced to the same level. Andrews (2008b) cites an example of a Chinese American Nurse, who was told by an Irish American doctor to increase the frequency of taking a patient's observations. This she did, even though she felt it was unnecessary. The nurse in charge of the unit later became annoyed when she found out this had occurred, and felt the nurse should have confronted the doctor about the order. The nurse had deliberately chosen not to confront the doctor, as her value system was similar to that used by many people from eastern cultures. This is to manage conflict using a collectivist style, which is where covert conflict prevention strategies are used to minimise interpersonal conflicts and the aim is to foster harmony (ibid). The nurse in the above case study had chosen to respect the doctor as being the authority figure and did not wish to

cause any disharmony in their nurse-doctor relationship. The nurse in charge was from a more individualistic culture (American), where overt confrontation of ideas and arguments by reason, tends to be the style more frequently used (ibid) and took the view that the doctor was a colleague, not an authoritative figure. Consequently, being assertive and having direct communication about issues would have gained that doctor's respect. This skill in being assertive is one which needs to be focused on during adaptation programmes, but is one which the nurses find very difficult to deal with:

'It is difficult to challenge and be more assertive with other nurses as it is different to being at home. This was because of being new to the place and not sure of the correct policies and procedures in being able to challenge others' (Group interview 6).

These views were also found in the study by Moore (1999), where nurses from the Philippines expressed their surprise at the autonomy British nurses had in making decisions about improving and co-ordinating patient care. The Filipino nurses found that British nurses were more assertive, whereas they were used to being told what to do by the medical staff. Taylor (2005) also found this in her study, where the overseas nurses expressed an increased level of job satisfaction, as they had an increased level of autonomy, which was different from that which they had experienced at home. The Filipino nurses in Taylor's (ibid) study had been used to working in a culture where they followed the doctor's orders, such as giving treatments, when told. When nursing in the UK, they found that if, for example, a doctor said that a patient could go home but the nurse felt it was not safe for the patient so to do, they could refuse to carry out that order. They found this to be very different from the nursing practice with which they were familiar. This difference in the decision making power base could also be due to cultural differences as discussed by Giger and Davidhizar (2008), who say that Filipino nurses would rather say nothing than have to disagree, particularly with someone in authority.

Theme 6: Attitudes experienced by overseas nurses when working in the clinical area

Some of the nurses in Taylor's (2005) study recognised that it was important that they had support when going into a clinical area for the first time, as they lacked confidence with the English language and with local policies and procedures. They felt that as they grew in confidence, the recognition of their abilities by others also increased. The nurses in Taylor's study (ibid) found with time, they began to make an effective contribution to the workplace, which was also a finding of this research study.

Sub-theme 1: perceptions of the overseas nurses and the negative attitudes they experienced

From this study there was a sense that British nurses did not fully understand what it was like to be an overseas nurse working in the UK. This was compounded by the fact that the adaptation nurses felt that they had experienced implicit racism, or arguably bullying, not only from other professionals, but also by patients and their families. Culley and Leatham (2001) in their study, cite many different examples of the overt abuse the nurses experienced in the hospital setting, which they felt was in the main due to the colour of their skin. Interestingly some of the overseas nurses in Culley and Leatham's study, who were overseas nurses working in the community with a caseload of Asian patients, said that they had not experienced any form of racism. Lee (2004) in her study found that British nurses who had gone overseas to work experienced racism which came as a shock to them. The nurses found they had to learn to develop confidence in feeling different or being made to feel different and find strategies to manage it.

Careful consideration was given to the interpretation of the data that was generated in this study. From the material presented below, it was initially very easy to reach the conclusion that the overseas nurses in this study had been subjected to explicit overt racism. However, if one did not know that the nurses were from overseas, one could interpret the majority of the comments as the nurses having been subject to bullying. The definition of bullying is very difficult, but can include aggression, intimidation, and harassment (Hadikin and O'Driscoll, 2000). All are effectively behaviours which could psychologically harm the recipient. Whilst a long list of behaviours could be cited, the findings of the research study conducted by The Royal College of Midwives into bullying in Midwifery (RCM, 1996) encapsulate the key findings from this study. The RCM study (ibid) found the following behaviours to be the most common; intimidation, undervaluing of skills, humiliation, belittling of work, questioning of professional competence and excessive criticism. All these have unfortunately been found in this research study. These behaviours, particularly if coupled with perceived racism, compound the effects of the bullying on the individual. Given that the respondents were not explicitly asked if they felt they were subjected to bullying and/or racism, the distinction is very difficult to make from the researcher's perspective. This is supported by Bheenuck et al (2006) who feel that the extent of racial harassment in the NHS is difficult to quantify, as it is not always possible to determine whether the untoward behaviours experienced by black and ethnic minority nurses are racially motivated. As a result, no attempt will be made to try and differentiate between

what is racism and what is bullying, as it would be unfair so to do, although this respondent felt that skin colour did have an affect on the way people are treated:

'Its just not adaptation nurses who feel they are treated differently by UK nurses. On my ward there was a black student nurse [UK trainee] who felt she was treated as an NA [nursing auxiliary]' (Group interview 4).

Some nurses sadly seem to accept this behaviour as part of the 'challenge' of their job and accepted the verbal comments and non-verbal behaviour of others towards them, as was described by this nurse;

'I am having a hard time communicating with parents and relatives. Some parents they have a hard time understanding our English communication and vice versa. When explaining or updating them regarding their child's condition, we do not know if they understand or not. Sometimes if you ask them if they understand they will just say yes. Then the next day you find out that they complained about you to other staff that they did not understand what you told them. Still racism cannot be avoided, we always experience and they will give us a look as if they are asking what I'm doing here in the UK and some parents will not trust us if we can do the same job as what the other staff can do. How did I manage it? By practicing and learning their accent so I can understand them, doing my job well so that I can prove to them that I have the confidence also that I know what I am doing. I have been working all my life in other countries so I have learned how to adapt to everyone's culture and racism cannot be avoided everywhere I go' (Group interview 6).

The above comments are also similar to those reflected in the research carried out in Iceland by Magnúsdóttir (2005) and a study by Taylor (2005), who reports instances where overseas nurses (non-white) experienced rejection or even dislike by patients, who made it clear that they did not want the nurse to look after them. Magnúsdóttir (2005) also found that relatives would not accept any overseas nurses, whether white or non-white, preferring to speak with an Icelandic nurse (the host country). Burner et al (1990) suggests this distrust stems from patients not understanding what a health professional is telling them. The patients perceive that someone with a different or foreign accent does not understand them or their needs, and this in turn can lead nurses to feel that their knowledge is not respected because the patient wants to talk to someone else. Beishon et al (1995) also found that racial harassment from patients was evident not just from verbal exchanges but from the non-verbal cues such as things that were not said, or the looks that were given towards the nurse by the patient.

One nurse in this study felt the response by the patient towards him was perceived as not being racist, but a subtle rejection by the patient of not wanting to be cared for by an ethnic minority nurse. However, given that 'white' nurses appear not to suffer from such

behaviour (Beishon et al, 1995), then one can only take this reaction as being that of a form of racism. This means that it is an issue that needs to be addressed, although it remains a challenge as to how healthcare professionals can change overall culture and ingrained personal beliefs of patients towards their nurses.

Unfortunately, this negative attitude does not just emanate from patients and relatives, but from other nurses and was a very disturbing finding of this study as the examples below show:

'One nurse is totally unapproachable...[she says] "can't you see I am busy", it makes you not want to approach her or ask her for advice. I will wait until I can get to ask someone else or will only ask her if I really have to. Not sure if this is because I am new, I am only checking as things are done different here and I want to make sure I am doing things correctly. I feel that I burden other colleagues who are also very busy, because they are approachable' (Group interview 6).

Asking for advice and checking with host nurses that tasks are being correctly completed, was also found in Scholes and Moore's (2000) study. The overseas nurses explain that because of communication differences, the meaning of what is needed to be carried out were not clear and as a consequence they had to stop and think about every action they were to undertake. They felt that they were trying to make sense of situations both simple and complex, that they had once taken for granted in their own nursing culture. They now needed to ask questions and seek clarification, ensuring actions to be undertaken were verified by a host nation nurse. Alternatively, the nurses in Scholes and Moore's (2000) study said that under the guise of being a 'foreign student' they felt comfortable in being able to ask naïve questions. However the findings from this study show that being a foreign nurse and asking naïve questions may not be viewed in the same light by the host nation nurses, as is demonstrated by the following extract:

'Some staff are supportive and give answers but some not. When it is busy it is difficult and makes me worried for example the other day looking after my patients I notice they need ten pm drugs. I ask the nurse [British] who says "I haven't got time, you do it" I say I can't as I am not [drug] assessed so she says "well you will just have to wait". I am then worried until two am until the patient gets their drugs. I then go off the shift not feeling satisfied' (Group interview 6).

This incident of being unhelpful towards this nurse culminated in much more overt negative behaviour;

'I am made to feel guilty, as one nurse will ring another ward saying "I have got a useless nurse here who can't do anything, can you help..." It makes me feel useless' (Group interview 6).

This marginalization can manifest itself in many ways. Hagey et al (2001) in their study found a nurse who described it as ‘one thing to the next, nit-picking, nit-picking, nit-picking...’ and was a situation unfortunately also found in this study, as one nurse described her experience of the behaviour she was subjected to, from a more senior nurse on her ward:

‘One nurse I thought was really helping me and teaching me. During every shift I worked with her she asked me lots of questions about my patients and why I had not done certain things. After a while [several weeks] I suddenly thought, “you are not teaching me but criticising me” and so I had to challenge that which was not nice’ (Group interview 6).

These comments are very uncomfortable to read and acknowledge. Not only is it an unacceptable way to treat another person; the actions (or inactions) by the British nurses in a ward environment could potentially be putting patients’ lives at risk. A converse argument put forward by the nurses in Winkelmann-Gleeds’ (2006) study defended their actions of needing to supervise overseas nurses. One respondent explained that overseas nurses can have an attitude, which says that they are a qualified nurse and that they do not need to be supervised. However, for the British nurse their responsibility is to ensure that the adaptation nurse is safe to practice, as they have a professional responsibility to ensure that when they are delegating a task to another person, that person is able to carry it out to the correct standard, or their own registration is in jeopardy. One example cited in Winkelmann–Gleeds (ibid) work was that of drug administration. The overseas nurses during their adaptation programme found it difficult to reconcile the fact that prior to coming to the UK to work they were used to giving out medications autonomously, but now discover they are not able to do so in the UK without a Registered Nurse being present, until they themselves are registered with the NMC.

Two of the nurses in this study acknowledge the difficulty in challenging the relevant nurse over events that they had experienced and this has clearly made a lasting impression. Culley and Leatham (2001) found that the nurses in their study had not been given any advice or training in how effectively to challenge untoward behaviour in the work situation. They found that the nurses felt that some of the abuse was down to attitudes, gestures, looks and tone of voice, which would make it difficult to report. The nurses then went on to say that even if they were to report such events, they were sceptical as to the action that would follow from it. They felt that they would be labelled, as being ‘over-sensitive’ and that very little change would occur if they did report their experiences. Hagey et al (2001) found this was indeed the case in their study and suggest that for

nursing, racism, whilst attracting attention from outside the profession, has not been acknowledged from within the profession and that much needs to be done. They go on to say that nurses should be taking a lead in practicing equity and integration at all levels of employment and professional life.

The fact that overseas nurses were subjected to behaviours that could be viewed as being racist and/or bullying is unacceptable. It is acknowledged that this may not be a deliberate response to individuals, but that of a learned response to being a professional, working in a culture that has been shaped over many generations, where the procedures and values to maintain high standards are jealously guarded (Day, 1994). Whilst nursing has shown that it is open and adaptive, by disregarding procedures and working practices which might disadvantage people from minority ethnic groups, it comes at a price. The profession is awarded lower status than those professions who are more elitist and self-perpetuating and this itself can cause conflict between professional groups (ibid).

To overcome some of these problems, British nurses must learn to respect and value their overseas colleagues, both as people and as nurses (McGee, 1994b). Winkelmann-Gleed (2006) suggests that for all parties involved, there needs to be a change in behaviour, whilst the whole team gets used to the boundaries, challenges and responsibilities of the UK healthcare system. British trained nurses need to have patience with new comers until they get used to the NHS and the 'British' way of doing things. Further, British trained nurses need to try and have an understanding of the 'normal' ways of working for overseas nurses and recognise and value the adaptation nurse's previous professional ways of carrying out their nursing function. In turn, overseas nurses are themselves in a unique position to share with others what it means to be a member of a particular ethnic group. They can provide guidance and help on appropriate nursing care and contribute to the elimination of bias and racism within the health care setting (McGee, 1994b).

It may be that negative attitudes towards individuals are not always because a nurse is undertaking their adaptation programme, or because they are non-white or non-British, but because they are a newcomer to the team as the following quote demonstrates:

'There is poor expectations nurses do not look after nurses. I was on the ward, in charge, one day and as I was the only qualified nurse on the shift I was sent a bank nurse who was Indian. I proceeded to explain to the bank nurse what needed to be done and explained a few pieces of equipment to her. The Nursing auxiliary said to me, "let her get on with it, you don't need to explain all of that to her". I could not believe that the nurse [auxiliary] said this to me. I mean back home if someone is sent to us to give us a hand, we welcome them saying "thank you very much, let me

show you what needs to be done". Here it is different, I am registered with the bank but am wondering if I will be treated the same way if I go to work on a ward that is not my own – it has put me off doing any [bank] shifts' (Group interview 1).

Taylor (2005) suggests that this phenomenon matches that of social identity theory. This is where an 'in group' develop their own desirable features and so to belong to an 'out group' that does not share the same features. This leads to the 'in group' bolstering their own self concept, by viewing those in the 'out group' in a less favourable way than themselves. For the overseas nurse (or any other nurse for that fact) going to another ward to help, would be viewed as not being part of the 'in group' and so are perceived as not belonging to the dominant group (a member of staff for that ward) and so are treated as a guest or visitor, who requires special treatment. Taylor (2005) also found that the overseas nurses did acknowledge that it was not only they themselves, but also any other new nurse to the team who were 'watched'.

This study mirrored the findings of Taylor's (2005) study, in that the overseas nurses felt that the expectations of their performance by British trained nurses were high and possibly excessive, with the overseas nurses feeling that they needed to prove themselves, in order to reach a stage where they feel they are trusted by their colleagues:

'Expectations by UK nurses of adaptation nurses are high... you are qualified you are seen as coming from a different background. They [HCAs] keep an eye on you and then complain [to the British registered nurses]' (Group interview 4).

This comment was an interesting one and has also been recognised by Winkelmann-Gleed (2006) who explores the problematic relationships which can often occur between overseas nurses and the nursing auxiliaries. These she suggests are because there is a shortage of qualified nursing staff and means the overseas nurses have to depend on the lesser-trained nursing auxiliaries for help with nursing procedures. In turn, these nursing auxiliaries feel that their jobs are threatened by the overseas nurses and so will report any mistakes to more senior nursing staff. This issue has arisen as a consequence of the tensions between HCAs and registered nurses and not just between overseas nurses and HCAs. Bach et al (2008) argue that HCAs have acted as substitutes for registered nurses over many years, with unacknowledged role boundaries being very fluid due to the complex socio-political interactions which have occurred over time at different policy levels (Spilsbury and Meyer, 2005). Bach et al (2008) describe how the role of the HCA has evolved from being that of a traditional role, where the HCA did what was needed to get the work done and posed no threat to the registered nurse. This is in contrast to the situation today, where the HCAs feel they can no longer be stereotyped as being 'untrained' or 'unskilled', and now pose a threat

to the registered nurse. Although this varies greatly from institution to institution, what compounds the problem is the role of the HCA not being clearly defined and not valued (ibid). Spilsbury and Meyer (2005) found in their study that the HCAs resented the registered nurses, were frustrated with their own role and felt that their knowledge was not valued. The registered nurses viewed HCAs as being the 'eyes and ears' of the ward, and those registered nurses who recognised this contribution HCAs made to patient care, gleaned a lot of patient information to help them in their own role. Having this information also placed the HCAs in a powerful position as they were able to have an indirect influence over nursing decisions. The other information HCAs in Spilsbury and Meyers (2005) study had, was organisational knowledge which also helped build their power base. The HCAs exerted control by withholding information such as the quickest way to obtain equipment, as they knew the 'right' person to ask. Whilst the registered nurses in Spilsbury and Meyers (2005) study recognised the contribution of HCAs to patient care, the HCAs were not rewarded for taking on this responsibility and it often went unrecognised. The HCAs reported that this 'hidden' work was often done to cover gaps in care left by staff in 'higher' positions such as junior registered nurses and student nurses. This caused some resentment as the HCAs felt they were telling others what to do and how to do it. As a consequence, the HCAs did not always support the registered nurses when care tasks were delegated, and this made the working life of some registered nurses uncomfortable as the HCAs made it clear did not want to work with them.

The real reasons for the behaviour of the HCAs seen in this study were not researched and so its true cause cannot be established. From what has been said by the adaptation nurses, one could infer that the overseas nurses were registered nurses and should 'know' how to do something and that they, the auxiliaries, are the 'lesser' qualified of the two groups. Therefore, the auxiliaries should not have to show the more highly paid and qualified nurse how to carry out basic tasks such as how to use a blood pressure machine. Winkelmann-Gleed (ibid) suggests that there is a sub-culture developed by auxiliary nurses, where they see themselves as the 'boss' of the ward and speak their own language when they gather together. Anecdotally, this phenomenon is recognised by British nurses as occurring to themselves, if they move to a new clinical area. It is recognised as being very difficult to manage and only settles or becomes less of an issue, once they have been accepted by the auxiliaries.

This issue of the nursing auxiliaries was also found in Taylor's (2005) study, where an auxiliary nurse commented that no matter how 'high' in promotion terms the overseas

nurses got in their own country, they had to start at auxiliary nurse level. Whilst the relationships between the auxiliary nurses and overseas nurses were not explored any further in this study, it is an area which could be worthy of further research. This is particularly because the apparent lack of awareness by British nurses of the skills and knowledge that overseas nurses have is compounded by the behaviours of the auxiliaries, which serves to reinforce their junior status.

This perception of the junior status of overseas nurses is one possible reason for the lack of promotion given to overseas nurses. DiCicco-Bloom (2004) found in her study that the overseas nurses were overtly discriminated against and prevented from being promoted. She reports on nurses feeling that they had to prove themselves to superiors, time and time again that they were worthy of promotion, to find that less experienced British trained nurses received that promotion instead. In his study, Buchan (2003) found that nurse managers expressed concerns that the overseas nurses were undervalued when they were first employed and that their experiences and skills warranted a much higher grade than the one they were given. This was not raised as an issue in this study, with no one reporting that they were feeling held back in their career because they were an overseas nurse. Interestingly all but one of the nurses in this study were at junior Staff Nurse level in terms of pay band, no matter how many years they had been in the UK. Winkelmann-Gleed (2006) acknowledges that there is an issue of being paid a low grade on coming to the UK and argues that migrant nurses are often very experienced professionals, as well as mature individuals, who find they have to start again at the bottom of the career ladder in Britain. This can be daunting, not only for them, but also for those working closely with them.

Conclusion

There were significant issues which the nurses in this study had to deal with. These included language and communication, expectations and understanding of own and other cultures and the attitudes experienced by overseas nurses when working in the clinical area.

The first challenge was with language and communication skills, for which the nurses had been unprepared and which caused some to become uncomfortable. It affected many of their interactions with others, until they gained confidence. The biggest hurdle to overcome was in understanding the English language and in particular verbal language and all of its complexities such as slang, humour and dialects. This was also a two way problem as the overseas nurses had difficulty themselves in articulating clearly, which lead to barriers

being put up between the overseas and British nurses as both parties were seeing an issue from their own cultural point of view.

The adaptation nurses shared their experiences of working with others from different cultures whether patients or other colleagues. This in some cases was a new and different experience for them and as a consequence they formed their own stereotypical views of people from other cultures, such as the British like to drink tea. For some of the nurses in the study the status of nursing as a profession in the UK was at odds with the prevailing status of how the profession is regarded at home. In particular the role of a hierarchy and the respect that needs to be shown to others in more senior roles. This in turn meant that the overseas nurses had to think differently and unlearn (or manage) their own cultural behaviours and views in order to be seen as being part of the team. As part of this, the overseas nurses had to manage their relationships with the healthcare assistants. They had their own power base derived from their own values and norms and as a consequence could make the working environment difficult for others, in particular the overseas nurses.

The most disturbing finding of this research study was the negative attitudes experienced by overseas nurses in the clinical area. There was what appears to be a culture of bullying and arguably, racism from patients and staff towards overseas nurses. Some of this was covert but some was blatant. It caused a lot of anxiety and upset for the overseas nurses, who felt they were trying their best to adapt to their new working environment and to do the right things but this was undermining both their efforts and their confidence. This was also seen in the study conducted by Alexis et al (2007) where the nurses expressed that they felt they were being watched all of the time and relatives would bypass the overseas nurse to seek information from a British trained nurse. Whilst discrimination is illegal, finding evidence of discriminatory practice within an organisation can be difficult to determine (ibid) and is possibly a symptom of the dominance and power exercised by British trained nurses against their overseas colleagues.

The next chapter will present a theoretical model which has been developed from this research study and demonstrates the key components which need to be incorporated into the curriculum of both adaptation and British nurse training in order to manage the 'sameness' and 'differentness' between British trained and overseas trained nurses. This education is pivotal in helping prevent the cultural clashes, which can occur if there is little understanding of another's culture whether they are a fellow colleague, patient or member of the public.

CHAPTER 7

A MODEL FOR MANAGING CULTURAL DIFFERENCES

Introduction

This research began by looking at the literature relating to educational management and its application to nurses completing an adaptation programme. What emerged strongly from this review was that culture was a critical concept that needed to be addressed during an adaptation programme. The conceptual framework of culture and the experiences of 'sameness' and 'differentness' by adaptation nurses emerged as a key focus for the study.

As a result of the data collection and subsequent analysis, significant findings became apparent and these are presented below, against the original three research questions. What emerged from the research findings is the adaptation programme, overall, did prepare the nurses for working in the UK. What it did not manage well was the individualistic personal and professional issues, such as managing cultural differences and learning higher level clinical skills, which for some nurses had a profound negative affect on them.

From these findings, a model emerges which illustrates how the above issues can be overcome and suggests ways in which they can be managed. This will require structured educational programmes not only for adaptation nurses but British trained nurses as well.

Research question 1: Does the adaptation programme offered by one Hospital Trust in England manage the cultural differences between adaptation nurses and British trained nurses?

The adaptation programme was focused on managing the communication issues that the overseas nurses faced. The nurses felt they had been supported in this aspect of their transition to working in the UK, although local colloquialisms and accents did cause some problems. The nurses however were quick to assert themselves and ask for clarification of what was being said. They were also given a lot of support on their professional development days to talk through these issues with other colleagues and the adaptation nurse managers.

What the adaptation programme managers did not manage very well were the cultural differences between the adaptation nurses and British trained nurses. As a consequence, this study found examples of covert and overt racism/bullying of overseas nurses by British trained nurses as well as by patients and their families. From this study it is difficult

to gauge the extent to which this was experienced, or why it occurred but it was an important finding.

It also became clear during the study, that the adaptation nurses had not previously shared their negative experiences with anyone else in authority. It would appear that this outcome had not been anticipated or recognised by the organisation or adaptation course nurse manager. Whilst professional development days were available where the adaptation nurses met as one group with the adaptation course managers to discuss issues, it would appear these very personal and sometimes painful experiences were not discussed at the meeting. Maybe these issues could have been foreseen and needed to have been managed, although it is appreciated this is not easy as the adaptation nurses had not raised any concerns at that time. It needs to be recognised that bullying and discrimination does indeed occur in institutions such as the NHS, and needs to be dealt with on a whole organisational as well as an individual level (DoH, 2005). The nature of such behaviour, particularly if undertaken on a persistent basis against an individual, can be very damaging to that individual, causing much distress and leaving them feeling isolated and threatened. This in turn can affect their performance and lead to hostility from others, which can detract from the work of both the team and the individual in delivering a service.

From this study, it appears that the adaptation programme managers tried to manage the cultural differences between the adaptation nurses and British trained nurses with communication skills. However they failed to provide the adaptation nurses with the knowledge required to manage cultural differences or, perhaps more importantly, provide them with support when they had a negative experience. This was compounded by the fact that the staff in the clinical areas where the overseas nurses were going to be working had not received cultural awareness training by the organisation.

From the findings of this study it appears that the organisation did not adequately prepare and manage the cultural differences between adaptation nurses and British trained nurses and, as a consequence, there were difficulties experienced in the clinical areas.

Research question 2: How well does the adaptation programme prepare adaptation nurses for working in the United Kingdom?

The adaptation nurses were very grateful for the support and help they had during their adaptation period from the adaptation course manager and fellow overseas colleagues. Some also felt they had really good support from managers and other nurses in the clinical

areas but sadly this appeared very much to occur in isolation and was not a key finding of this study.

It was clear from this study there was a lack of recognition of the higher order of clinical skills that overseas nurses had, including male catheterisation, venepuncture and giving intravenous drugs. These skills are taught as an essential part of some overseas nurses' basic nurse training, but are skills that require extra training in the UK. The adaptation nurses in the study felt that if it was a requirement that these skills required additional training then they should have been completed during the adaptation programme and not left until after the programme had finished. The lack of this gave two damaging outcomes.

Firstly, at the completion of their adaptation programme the nurses were not able to work fully in the clinical environment, as they had to undertake additional training for what they perceived to be basic skills. As a consequence the adaptation nurses, felt deskilled and demotivated.

The second outcome of this lack of skills training was that British trained nurses perceived them to not be fit for purpose and a burden. There was also the frustration that the adaptation nurses having already undergone significant time out of the clinical area during their adaptation period, were to be given 'yet more' training and hence time out of the clinical area to undertake these skills and this was perceived to be unfair by British trained nurses. Arguably this can again be seen as a failure of the organisation to manage the adaptation programme adequately. The findings from this study reflect those of Taylor (2005) who also found evidence that there is a lack of recognition of the skills and experience that adaptation nurses have which results in them becoming de-skilled and feeling that they have to prove themselves.

Overall the adaptation nurses felt that the adaptation programme prepared them adequately for working in the United Kingdom, although some aspects such as advanced clinical skills should have been taught during this period. Doing this would have helped the nurses become integrated into the team more quickly on successful completion of their course as they would have been able to carry out all skills themselves and not have to rely on their colleagues. This in turn would have helped reduce any resentment from colleagues because the need to have additional study time to learn these skills would be removed and this would have potentially reduced some of the unpleasant behaviours which have been seen in this study as a consequence of these skills gaps being present.

Overall, the adaptation nurses' felt the adaptation programme prepared them adequately to work in the UK.

Research question 3: To what extent did adaptation programme meet the cultural and professional needs of the adaptation nurses?

Some of the nurses from this research study described very positive experiences during the period of their adaptation programme but there were some important negative experiences which emerged. It is clear that the value and worth of the overseas nurses in this study was not as high as it ought to be because of perceived cultural and professional differences and this caused some upset for the nurses concerned.

The adaptation nurses were aware of the importance of professional regulation before coming to the UK as they had already had contact with the nursing professional body, the NMC, when applying to come to the UK as a registered nurse. The biggest change in their practice was the prolific volume of patient related paperwork in the UK in comparison to "home". On the whole the nurses felt supported with their professional development and were pleased that they were to be afforded opportunities to undertake further studies if they so wanted. Their only frustrations were with clinical skills where they knew 'how' to conduct a task or skill but were not trained in how to use the particular equipment used in the UK as these were different to those used at home.

Culturally, the nurses found some things that came as a surprise to them both inside and outside work. It is possible that the preparation that they carried out prior to coming to the UK may not have been enough. Pross (2003) and Lee (2004), in their research into 'western' nurses, found that even though the nurses felt that they had researched and prepared for their trip sufficiently prior to departure, they were just not prepared for what they were to experience once they arrived overseas. There were two main challenges they faced. The first was the need to settle into the new country and have to accept and cope with what they saw and experienced, no matter how shocking or different it was to them. The second challenge was that there was difficulty in accepting that this was a lifestyle that was different from their home country, and realising that they had to fit into the new culture, because the new culture would not fit around them. In other words, the students had to unlearn their own cultural belief systems in order to fit into the new environment (Ibid). So, in preparing adaptation nurses for working in the UK, some form of cultural awareness and sensitisation education needs to take place before the nurses leave their home county. Once in the UK the adaptation nurses felt that to be mentored by a nurse who

has undergone the adaptation programme himself or herself would have been invaluable to them, and would have helped to minimise the effects of adapting to a new culture.

As a minimum, there should be some form of cultural training for the staff in the clinical areas where the adaptation nurses were going to be working. The focus of this training needs to address the definition of culture and how the 'sameness' and 'differentness' of our own life experiences compare to others, as well as explore how we value others and ourselves. There needs to be an emphasis on the value of working with colleagues and patients from overseas, and not trying to understand in minute detail the 'differentness' and 'sameness' of each others' cultures. Holland and Hogg (2001) also support this view and say that when incorporating information about cultures into training programmes, it has to be in an easily accessible and transferable format. They say that nurses may find that the detail on different cultures interesting, but unless it can be used at the point of contact it will be of little value to them. Therefore, it needs to be real and practical.

Having explored and interrogated both the personal and professional issues that overseas nurses faced during their adaptation programme, it is clear is that there is an obligation on the nursing profession educators to deliver all curriculum in a way which educates practitioners in the cultural requirements of being a nurse in the UK. That is, how to provide nursing care that is meaningful for, and sensitive to, the needs of patients from all cultures (Lynham, 1992).

An emergent, heuristic model

The model below (figure 7.1) has emerged from the literature reviewed and findings of this research study, and will be of interest to both curriculum planners and teachers of nursing.

The model illustrates how one's own culture and the culture of others are related and how cultural clashes can occur if there is little understanding of the 'sameness' and 'differentness' between each culture. For the adaptation nurses there are elements of knowledge and understanding that will help them to be able to work confidently and integrate into UK culture. For British trained nurses there are dimensions of understanding other cultures, which if incorporated into the nursing curriculum would facilitate the nurse to think about delivering culturally competent care as well as helping the working relationships between different groups of staff coming from different backgrounds.

To complement the above, the model for the development of transcultural skills described by Papadopoulos et al (1998) underpins some of the key features of the model developed

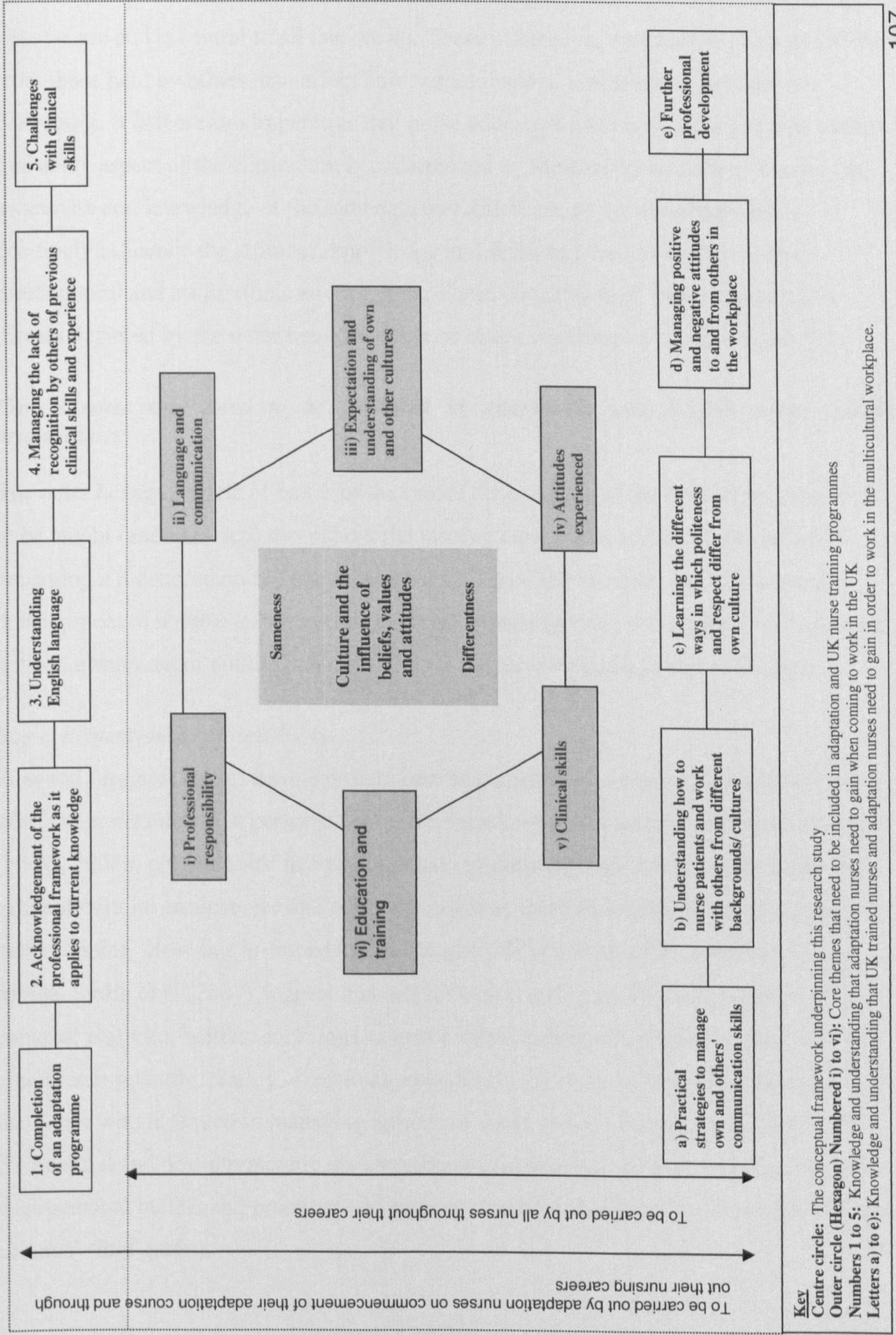
from this research study, mainly because it focuses on 'how' individuals develop their transcultural skills through the education process. Practitioners gradually develop their knowledge and skills of how cultural and social factors can have a significant effect on health and care. This process of education through different stages leads to a point where nurses become culturally competent and the normalisation of anti-discriminatory and anti-oppressive practices is achieved. The models developed by Papadopoulos et al (1998) and others (for example, Giger and Davidhizar, 2002; Purnell, 2002; Littlewood, 1989), show how nurses organise their knowledge of cultural information and apply this in the clinical situation to ensure the delivery of culturally competent care. Whilst the model arising from this research also advocates this, it is not the key focus. The contribution this model makes to this field of study is very much focused on demonstrating how individual nurses and managers educate and develop the overseas nurse's personal and professional self, so they can become integrated into the multicultural workplace. If this is done within a transdisciplinary, transcultural health care framework (Glittenberg, 2004) it will not only support individual nurses who need this development, but will enhance their knowledge and ultimately the care that patients receive.

From the outset, it was the intention that this research should find some generalisations for the host institution where the research was conducted, in order to improve future adaptation programmes. The model that has emerged clearly illustrates the interrelationship of the knowledge and understanding needed by all nurses, not just adaptation nurses, when working in a culturally diverse workplace, which is a key feature of today's NHS.

The model below (figure 7.1) represents the core themes that have emerged from the data collected from this research study and illustrates the issues that need to be taught and embedded in both adaptation and traditional nurse education. Nurses need to be made aware of their responsibility in responding to each of these components and the effects that can occur if they are not acknowledged and acted upon. What the model is saying is that working in multicultural Britain is a dynamic situation. Adaptation nurses need to meet the professional requirements specified by the NMC to become recognised as a registered nurse. At the same time, they need to be developing their cultural knowledge and skills, which is also a requirement of British trained nurses, in order to ensure they deliver care that is culturally appropriate and that working in a multicultural workplace is harmonious. This is a dynamic process and is not a 'one off' event. It requires all nurses to demonstrate commitment and continual education and reflection on practice to ensure that the care they

deliver is done in a culturally appropriate way and that workplace relationships are constructive Each component of the model will now be discussed.

Figure 7.1 – The interrelationship between culture and the key aspects that need to be incorporated into adaptation and British nurse training programmes.



Main conceptual focus

The central square in the diagram shows the conceptual framework underpinning this research study. That culture and the influences of beliefs, values and attitudes, make us who we are and is central to all that we do. These influences, whether the same or different from those held by others, can affect how nurses respond and relate to patients and colleagues. It is therefore imperative that nurse educators and curriculum planners ensure that every aspect of the curriculum is underpinned by the concept of culture. Having an awareness and knowledge of the sameness and differentness between individuals can positively influence the attitudes, knowledge and skills required to work in today's multicultural and multi-ethnic environment. These concepts need to be applied to the themes depicted by the outer hexagon circle of boxes numbered i) to vi) in figure 7.1.

Core themes that need to be included in adaptation and British nurse training programmes

The outer hexagon circle of boxes of the model depicts each of the core themes that need to be taught (and assessed) throughout the nursing curriculum as part of the route to becoming a registered nurse. The focus needs to be on the personal and professional development of a nurse ensuring the skills and knowledge they are taught is underpinned with an awareness of culture and the effects it can have on patients and colleagues.

Box i) Professional responsibility

First and foremost nurses have a professional responsibility to ensure they deliver care which demonstrates '...a personal and professional commitment to equality and diversity' (NMC, 2008b, p5). To fulfil this professional requirement, nurses need to be taught the skills of cultural competence and cultural sensitivity as a core competency during any nurse training. How this is embedded and taught will be for individual institutions to decide. Smith et al (2007) suggest that self reflection and systematic examination of personal attitudes, beliefs, conscious or unconscious attitudes is vital in helping the practitioner towards treating all patients respectfully. This can be delivered through a facilitator who is skilled in managing structured small group teaching sessions in a confidential and non-threatening environment where learners are encouraged to 'examine their personal beliefs and practices and compare them [to the] beliefs and practices of other cultures' (ibid, p656).

Box ii) Language and communication

Nurses need to be able to communicate and negotiate across cultures and languages in order to provide effective patient-centred communication and care that is ‘...compatible with patients’ cultural health beliefs and practices and preferred language’ (Smith et al, 2007, p658). This is a difficult task, and it requires the nurse to build on their cultural awareness, through gaining cultural knowledge. The next stage is to turn this knowledge into the skill of being able to engage in cultural interactions with patients and be able to prescribe appropriate culturally sensitive and appropriate care plans to meet their needs. From the literature, for example Smith et al (ibid), it is recognised that there are several ways in which patient centred communication can be taught to health professionals and they do not advocate any particular model. What is clear from their paper is that different approaches will work in different settings and scenarios and this is what educators need to keep in mind when planning and delivering the curriculum.

Box iii) Expectation and understanding of own and other cultures

To support the acquisition of cultural competence and sensitivity there is a need for the nurse to understand and be aware of the expectations of their own and other cultures. To be able to facilitate this, the focus needs to be on obtaining the individual nurse’s engagement in the process. They need to be heavily involved in a process of self-reflection and discussion with others on difficult cultural issues they may have experienced. Such experiences may be racial mistrust, previous negative experiences or their own biases. If this is supported by the use of relevant case studies it can be a very powerful approach to use in developing the nurses skill and knowledge that in cultural competence and sensitivity. It is also acknowledged in using this approach negative responses can be provoked and these need to be skilfully managed by the group facilitator.

Box iv) Attitudes experienced

Developing this cultural knowledge and skill will in turn affect the nurse’s attitude to their patients when delivering care. There is no doubt that attitudes can influence healthcare practice and is something of which nurses need to be very aware. In particular, if attitudes and behaviour are negative, then barriers can be put up which prevent positive care outcomes being achieved. This relates not only to patients but also to working with colleagues from other cultures, where misunderstandings can cause disharmonious workplace relationships.

Box v) Clinical skills

Having this cultural knowledge can help in the application of clinical skills. In teaching and assessing this skill the teacher needs to ensure that not only is the task conducted correctly but also that it is conducted in a way that is acceptable for the patient. For example assuming the skill to be carried out by a nurse is the taking of a patient's blood pressure. The teacher will observe and assess the nurse as to whether the [female] patient has been asked and is happy to reveal their arm to the nurse, especially if that nurse is male. If this is not acceptable to the patient that alternative options should be proactively sought. This illustrates the nurse has not assumed that the patient has the same beliefs and values as themselves, and that where these beliefs and values are different these are acknowledged and reacted to.

Box vi) Education and training

The education and training of nurses in culturally aware ways requires skill on behalf of the teacher. The teacher needs to be comfortable in teaching culturally focused care and have a personal commitment and attitude to ensure reinforcement of the key messages. They must also have an ability to negotiate and manage conflict. It is a complex task to ensure that there is individual engagement by each student and requires the use of different teaching methods including role playing, case study learning, didactic lectures or complex skills teaching using interviewing or physical assessment. The teacher must be skilled in knowing which method or combination of methods is the most effective and must continually evaluate the application of these methods to the group being taught. Throughout the curriculum, the teachers must keep the students focused on the fact that nursing is a life-long journey of learning, demanding that the nurse continually tries to understand a patient's background and apply the knowledge and experience they have gained. The teaching of culture needs to be integrated seamlessly into the curriculum as not doing so risks culture and cultural issues being segregated from the rest of the curriculum.

Knowledge and understanding that adaptation nurses need to gain when coming to work in the UK

The boxes numbered 1 to 5 in the model indicate what overseas nurses need to do, know and learn about, during their adaptation programme in order to be able to integrate into the new environment in which they find themselves.

Box 1) Completion of an adaptation programme

This is self-explanatory, as overseas nurses have to complete successfully an adaptation programme to be allowed to work the UK. The message from this study is that curriculum planners need to ensure that as far as reasonably practicable, each of the issues raised in this study is addressed during the adaptation period in order that the progression from 'student' to 'registered nurse' is as seamless as possible.

Box 2) Acknowledgement of the professional framework as it applies to current knowledge

In completing the adaptation course the nurses must be taught how nursing practice in the UK is conducted within a professional framework, which is likely to be different from that they have experienced at home.

The two big challenges faced by the adaptation nurses in this study were their understanding of the English language (box 3) and the lack of recognition by others of the clinical skills and experience they already had (box 4).

Box 3) Understanding English language

The curriculum for the adaptation nurses in this study did recognise the need for communication skills to be taught. In spite of this, the adaptation nurses felt that even with this recognition, communication was very challenging and they needed a good deal of help and support with their communication skills throughout the adaptation period. From the literature (Magnusdottir, 2005) it is clear that support may be required for a significant period of time afterwards. The skills of communication relate not only to the nurse's own needs but are also an essential element of them being able to function adequately as a nurse in a multi-cultural workplace. This therefore needs to be an integral part of the adaptation programme and contain tools that the nurses can use long after the adaptation course is complete.

Box 4) Managing the lack of recognition by others of previous clinical skills and experience

There are two aspects of the lack of recognition by others of the clinical skills and experience that the adaptation nurses already had which needs to be addressed. The first is that the adaptation nurses need to be taught how to manage the attitudes of others towards them. For some adaptation nurses this may be difficult to do. The adaptation nurses will need support to examine and understand attitudes such as mistrust, subconscious bias and stereotyping that can be present in the clinical environment. They then need to be provided with the skills to communicate effectively and to negotiate across cultures and languages.

Doing this, will in part provide the adaptation nurses with the tools to manage such encounters (Smith et al, 2007) and so reduce the negative effects which can ensue from such encounters.

Box 5) Challenges with clinical skills

The second aspect of managing the lack of recognition of the adaptation nurses' clinical skills was to ensure they were adequately prepared for undertaking clinical skills. The experiences of the nurses in this study where they experienced negative responses from others in relation to their clinical skills was avoidable, had the curriculum planners given the teaching of clinical skills adequate consideration. The issue should have been recognised and dealt with by the team responsible for teaching the nurses before they were allocated to the clinical area.

This could have been done with appropriate assessment of the adaptation nurses; by establishing the skills and knowledge the adaptation nurses had of current commonly used equipment in use at the hospital where the nurses were undergoing their training. For example, as earlier stated, the nurses could take blood pressures but were not familiar with the machines used in the UK. This assessment could then have been followed up with practical hands on teaching in the classroom, with equipment used in the UK to ensure the nurses readiness for the clinical placement.

Along with this, if they were also assessed on their "extended role" skills like male catheterisation and giving intra-venous drugs, this would also have avoided some of the frustrations found in this study, where the adaptation nurses found that even though they had gone through the adaptation programme, they needed to undergo further training after the programme in order to be able to undertake tasks they were fully skilled at and conducted routinely at home.

Knowledge and understanding that British trained nurses and adaptation nurses need to gain in order to work in the multicultural workplace

The boxes labelled a) to e) indicate that the curriculum (whether traditional British based training or adaptation nurse training) needs to acknowledge the sameness and differentness between nurses from different cultures and the host culture. This needs to be done in a way that informs learning and enables the delivery of culturally sensitive care when working with patients, as well as promote a congenial working environment when working with colleagues from different backgrounds. This requires an awareness of not only cultural

differences from the nurse's own culture, but the different uses of language and communication between different groups, to prevent the delivery of mixed messages.

Box a) Practical strategies to manage own and others' communication skills

All nurses need to be taught how to manage their own communication skills and respond to those of others. This can include, but is not limited to, identifying language barriers that may interfere with communication and how to overcome them such as by using different media (Johnson 1999). Cross-language training may be useful in certain geographical areas such as areas with a high population of minority groups. Likewise there may need to be training on local dialects such as those described by Witchell and Osuch (2002).

Box b) Understanding how to nurse patients and work with others from different backgrounds/culture

These must not be taught as single stand alone sessions. So doing, can put up the very barriers that need to be avoided. The information on different cultures needs to be interwoven throughout the educational programme in order that it is accepted as being the 'norm' and not a discrete topic. It would also help to avoid the experience of some nurses in this study where they arguably experienced discrimination, bullying and professional exclusion by colleagues, patients and relatives. Alternatively, even if these behaviours expressed by others cannot be totally eliminated, having the knowledge of different cultural norms can make understanding and hence managing the situation should it arise much easier to deal with.

Box c) Learning the different ways in which politeness and respect differ from own culture

Learning the different ways in which politeness and respect are demonstrated in other cultures is difficult to achieve. These concepts are closely interwoven with communication and an individual's cultural values and beliefs and so can be described. However, if they are deemed 'alien' to an individual they may not be able to understand and accept the prevalent norms. Their own values in relation to politeness and respect cannot be 'un-taught' and so it will take a period of time for them to adjust to the new environment. The issues to be taught in the classroom include the prevalent cultural beliefs and norms, why they are important and how they can cause offence if not managed adequately. An important skill which also needs to be learned is how to elicit an individual's cultural values and beliefs if they are not obvious or when dealing with an individual whose cultural preferences are not known. The goal for nurses in so doing is to try and accommodate the beliefs of the individual wherever possible, in order that they are treated

with respect and not inadvertently offended by any actions or comments during any interaction.

Being made aware of and given the skill set to deal with the items in boxes a) – c) can help prepare the nurses to gain knowledge of what they may experience once in the workplace. It will also enable them to rehearse their responses to some of the scenarios that may present themselves. That is they will proactively gain skills in managing such situations rather than passively developing coping strategies when faced with the unknown. This process sounds relatively simple but the reality is different, with the nurses needing to unlearn or go against their own cultural values and beliefs which is very difficult to achieve and for some it is impossible and needs to be managed carefully. Teachers facilitating the above three aspects of this part of the curriculum should take care not to allow cultural orientations to dominate. They should encourage the sharing between students of the different aspects and philosophies of care as well as the culture and practice drawn from different countries. This can then be used as the basis for the learning experience. This learning from each other, in a manner that acknowledges and celebrates cultural differences and sameness, can make connections between individuals, which can facilitate a mutually acceptable way of working and providing care to patients.

Box d) Managing positive and negative attitudes to and from others in the workplace

Managing positive and negative attitudes experienced by others in the workplace is again not an easy skill to learn. It is a life skill that comes with confidence and knowledge and often can only be gained after many years experience in a particular environment. Therefore to equip the nurses with the skills to reflect honestly on their own attitudes (which are underpinned by their own beliefs) and the effects these can have on others, is the starting point in them being able to negotiate and manage conflict situations and so needs to be a core component of the curriculum.

Box e) Further professional development

The professional framework sets out the requirement that all nurses must undergo continuous professional development (NMC 2008a) in order to remain on the NMC register and hence practice as a nurse. Whilst this is made explicit in British based training, there is a requirement that this should be the same for adaptation nurses, to ensure they are aware of their responsibility in ensuring their continued professional development, following the completion of their adaptation programme.

The model (figure 7.1) depicts which concepts should be incorporated into all nursing curriculum but not how it should be done, as to try and generate a universally acceptable conceptual nursing framework is futile (Scholes and Moore, 2002). What it does show are the key concepts that need to be encompassed within any nursing curriculum, in an attempt to ensure all nurses are equipped with the knowledge, confidence and skill set to work with patients and colleagues in today's multi-cultural society.

The discussions above and the findings of this research study suggest that the integration of culture into the nursing curriculum needs to be done in a meaningful and informed way for both traditional British nurse training and for overseas nurses completing their adaptation programme. What the model depicts is that each individual has their own cultural norm and this is influenced by one's own beliefs, values and attitudes that have been learned and developed over time. These beliefs, values and attitudes can be the same or different from those of other cultures and knowing and recognising this as a professional nurse is crucial when working and caring for others from a different cultural background. For an individual to try and undo any of their learned behaviours in terms of beliefs, values and attitudes is very difficult, if not impossible and so therefore needs to be consciously managed. For the nurse educator and curriculum planner, there needs to be a clear strategy to ensure the personal and professional aspects of culture are taught and managed throughout the nursing curriculum in a proactive way. This will serve to reduce the likelihood of cultural clashes occurring due to misunderstandings of cultural norms and as a consequence it will allow the delivery of culturally congruent care to patients.

Conclusion

This research aimed to establish what the critical components of an adaptation programme needed to be, in order to meet the cultural, educational and professional needs of these nurses. In exploring the experiences of overseas nurses working in one Hospital Trust in England, it was felt that overall the adaptation programme was effective in supporting and giving students time to settle into their new environment and was something for which the overseas nurses were very grateful.

The positive aspect of the adaptation programme was that it did try to meet the professional and educational needs of the adaptation nurses, by focusing on communication skills and the requirements of the nursing professional body, the NMC. As a consequence all of the nurses in the study successfully completed their adaptation course and were able to work in the UK as a registered nurse.

What the adaptation programme did not do was manage effectively the cultural, educational and professional differences between the overseas nurses and British trained nurses. As a consequence, there was a clash of cultures, resulting in some unpalatable outcomes. Clearly, the managers of the adaptation programmes in this study cannot be held personally responsible for the prevailing cultural attitude in the organisation where this research was conducted. What is in their gift, along with findings from research such as this study, is to lobby and influence curriculum planners and teachers to ensure that all nurses completing educational programmes are educated to identify with each other and become more culturally aware. This in turn, will not only help when working with colleagues from other cultures, but also in nursing patients who come from different cultural backgrounds. By addressing these issues throughout nurse education programmes, this will, over time, gradually change the prevailing attitudes in the organisation towards different cultural groups.

The biggest shortfall of the adaptation programme was in not recognising and capitalising on the clinical skills the overseas nurses already had. This lack of recognition caused the most angst and frustration for the adaptation nurses who felt they were being de-skilled. Further if these skills had been acknowledged and focused on during the adaptation programme and not left until after it had finished, the organisation would have seen these nurses functioning much more quickly as registered nurses. In so doing, it may well have prevented some of the culture clashes that were seen in the study. These problems and issues could have easily been avoided with careful thought and planning and form the basis of one recommendation from this study.

Looking to the future

As nurses move around the world experiencing new cultures and ways of working, they take with them a diverse mix of cultures, languages and views about what nursing is and how it should be practiced. Likewise the healthcare environments will be receiving these mobile nurses into the workplace. For all parties involved there needs to be a real understanding and appreciation of the 'sameness' and 'differentness' of each others cultures and a genuine willingness to accept them and work with them to ensure a happy and safe working environment for all and to improve patient care. The recommendations that follow are derived from the findings of this study and it is hoped that they will have some influence on policy makers, curriculum planners and nurse teachers when developing and delivering nurse education programmes.

1. Cultural knowledge and awareness is an integral (and not stand alone) part of all nursing curricula.

What has become clear from the literature and this study is that culturally competent care, which is delivered in a culturally competent manner, is a reasonable expectation in today's multicultural society. It is no longer acceptable to deliver care on the basis of norms drawn from the dominant culture, as by doing this, it means that care to the patient is not individualistic which is unacceptable (Papadopoulos, 2006). This means that British and overseas nurses need to be educated in what it is like to work in different healthcare systems and to value cultural diversity. The task of the professional educators therefore, is to teach the importance of respecting cultural patterns that are different from one's own in order to allow the health professional to deliver appropriate care (Culley, 1996). In so doing, this will help dispel the intolerance seen towards minority groups that is derived from attitudes and is characterised by apparent prejudice, but is arguably as a consequence of ignorance (ibid), not only towards patients, but to overseas staff. Bheenuck et al (2006) suggest that current education and training has had little impact beyond the raising of awareness of racial harassment and discrimination. What is required now they feel is an actual change in staff behaviour. This can be achieved if cultural knowledge and awareness becomes an integral, and not a stand alone, part of all nursing curricular.

2. Communication and language skills are an essential part of the adaptation nursing training programme.

Good verbal communication skills are essential for any nurse coming to work in the UK. There are significant issues that need to be overcome including understanding different dialects, colloquialisms, idioms, and different types of English such as American English. The awareness of needing time to translate a conversation into the nurses' mother tongue and back into English was a new experience for some nurses in this study and must not be underestimated. This issue may improve now that the NMC has stipulated the minimum levels of competence required in the speaking and writing of English before entry to the NMC register.

3. A mentor should be provided for all adaptation nurses and this person needs to have completed an adaptation course previously.

The adaptation nurses in this study felt that if they had been allocated a mentor who had previously completed their adaptation training it would have been of significant help and support to them, particularly in the first few months where everything was new and seemed strange.

4. Advanced clinical skills training needs to be completed during the adaptation training programme.

Instead of treating the overseas nurses as though they are newly qualified nurses who need to develop a new skill set, they need to be treated as the highly experienced professionals that they are. This could easily be addressed by the adaptation curriculum, which should be adapted to ensure that advanced clinical skills such as cannulation and catheterisation, are taught as early in the course as possible, in order that they can be used as soon as the nurses' registration with the NMC is confirmed. This should have the effect of British nurses treating the overseas nurses as equals.

The recommendation from this study is that the skill set of each nurse should be established right at the beginning of the adaptation programme. The focus should then be on getting the nurses fit to practice these skills in the UK as soon as possible. This will give the nurses credibility in the workplace, maintain their skills and will allow them to contribute more quickly to the work of the organisation. Preventing overseas nurses from gaining the training they require to use these skills until after their adaptation programme, on no sound rationale but the views of British nurses, is both unsound and a waste of resources.

It can be argued that the time served feature is a protectionist response by British nurses, who see these skills as 'higher order skills' and can only be conducted by those who are 'specially trained'. The reality is that for most overseas nurses, these skills are taught in their basic training. There is therefore nothing 'special' about them apart from the fact that they are essential in ensuring that the patient gets timely treatment.

There is another view of this phenomenon, which is the general perception that overseas nurses are viewed as being newly qualified nurses, rather than highly experienced and knowledgeable practitioners. It would be seen by the hosts that it is critical to get the nurses through their adaptation programme and registered with the NMC as soon as possible, given that the nurses were recruited to fill qualified nurse vacancies. Once they are on the NMC register, the hosts would then see it is appropriate, as it is with newly registered nurses, to allow the adaptation nurses to do extended skills training after registration.

This would reinforce the general philosophy found in this study, of British nursing being very singular in its approach to the way nurse education and training is delivered and

reinforces the view that this is 'how we do things here'. There is little evidence that the adaptation programme is responsive to the needs of the individual nurses based on their previous knowledge and skill, but is delivered in the traditional way following known processes.

5. The demise of the adaptation programme.

Whilst this study has focused on the experiences of adaptation nurses coming to the UK it has to be recognised that the number of adaptation nurse courses are now diminishing as the number of nurses in the UK have improved (Home Office, 2008). Given this situation the findings and recommendations from this study should still be applied to all nursing curricula and could be used by other industries where they have a multi-cultural workforce.

The next chapter will reflect back on this study and make suggestions for further lines of research that could be carried out in order to add to the knowledge that has already been gained.

NEARING THE END OF THE JOURNEY?

This study aims to make a significant contribution to the body of knowledge relating to the cultural care of both overseas nurses and the care of patients from ethnic minority groups. It leads the way for further work to explore how we interface with others in our ever-growing multicultural society, either with those needing health care or those who make up our nursing workforce. Indeed the findings could be applied to any other multi-cultural workforce.

With worldwide migration, there has been an increase in the number of nurses from diverse cultures working in the UK. This presents challenges for nurses and nursing, the workplace and the educational institutions responsible for academic programmes of study. This research study has explored the literature regarding the experiences of adaptation nurses. It investigated what the adaptation nurses needed from adaptation programmes to ensure their personal and professional needs are met. Creemers' (1997) work was useful to focus in on how the curriculum can be structured to be effective in meeting the external environment, organisational and student needs. This study suggests what content needs to be included in such an educational programme and is clear that a pro-active approach to addressing cultural issues within any nursing curriculum (whether adaptation, or traditional) is essential. This is a great challenge. Culture at an individual level concerns the way we think and interpret information. It is based on our life experiences. At an organisational level, it is seen as "the way we do things around here". These are based on the core values and assumptions derived from artefacts, stories, legends, myths, structures and systems (Usoro and Kuofie, 2006). McGee (1994b) suggests that the educational strategies need to ensure that students are able to deliver competent transcultural care. This should include the student being able to recognise their own values, as well as being able to explain familiar traditions to someone from outside their culture. This will demonstrate their openness to the cultural differences of others.

How institutions are able to integrate the above ideas and concepts into the nursing curriculum has its own challenges. It is recognised that whilst there are some suggestions in the literature as to how these issues can be addressed, (Papadopoulos et al, 1998; American Nurses' Association, 1986), they have a tendency to be prescriptive in the way cultural issues should be presented in the curriculum. One big step towards addressing this

issue was the publication in the United States of America on the standards and competencies that each baccalaureate nurse needs to acquire by the end of their nurse training (American Association of Colleges of Nursing, 2008). Although an excellent achievement in terms of establishing what needs to be achieved across all nursing programmes in a bid to ensure global agreement, the competencies present a strategic overview rather than an operational plan that can be used by nurse educators. Calvillo et al (2009) have attempted to address this issue by making suggestions as to how these standards and competencies can be applied in the clinical area and the types of activities which can be carried out in the classroom by students. These however remain at a very 'high level' and can be interpreted in many different ways. Bagnardi et al (2009) suggests a more dynamic and purposeful approach. They (ibid) propose that it may be more useful to ensure that the issues of culture are woven into every aspect of the educational experience, as opposed to being a separate area of study or applied in 'silos'. They suggest using a conceptual framework such as that developed by Banks (2006) as a powerful way to bring structure to the 'process of conceptualisation and implementation of multicultural education' (Bagnardi et al, 2009, p234).

Bagnardi et al (2009) used the five dimensions identified by Banks (2006) of; content integration, knowledge construction, prejudice reduction, equitable pedagogy and empowering school culture, and assigned each of these dimensions to the different stages within the nursing course where it would be addressed. The purpose of this was to provide a structure of what needs to be taught and when. At the beginning of the course the aim was to build the students' understanding of the basic concepts of diversity and its impact on health, care access and quality of care. At the end of the course it was hoped that the students will be committed to ensuring that there is equity for all who access healthcare. To achieve this will require them to continually reflect on diversity in education and realise that diversity education is an ongoing journey, rather than something which stops at course completion.

The method by which the subject of culture is taught is important. The traditional didactic method of telling the student what they need to know may stifle the need to question and challenge and may not fit the preferred learning styles of the nurse (Omeri et al, 2003). Learning involves feeling, reflecting, thinking and doing (Yamazaki, 2005) and educators need to understand how best to teach students with differing learning styles. Learning is a dynamic process and an individual can use any combination of learning style at any time. The responsibility of educators is to ensure that in delivering the curriculum there is a

balance of teaching methods used that complement all learning styles equally. There also needs to be some consideration as to the cultural background of each student. Each student needs to be given the opportunity to examine their own attitudes, beliefs, values and feelings and explore them in parallel with the experiences of others, as told by those individuals. This in turn will increase each student's understanding of the way others can be viewed, and how they are, or are not, accepted into other cultures. As Leininger (2000) suggests, it is not just about the curriculum, but the need for individual nurses, from wherever in the world they originate, to be committed to having a genuine interest in learning from others. If the nurses have a mutual understanding of the biases, prejudices and other attitudes, that people from different cultural groups have, it can help prevent the development of unfavourable relationships.

In planning their curriculum Bagnardi et al (2009) have given a great deal of thought to these issues. They developed a series of activities using a wide range of tools and techniques and mapped them to each of the five dimensions described by Banks (2006). These activities were very interactive; such as asking students to present to their study group, a 'cultural meal' or to read a book (or watch a film) based on actual situations. The nurses were then required to reflect on this experience and explore the meaning of the experience for them, such as identifying misconceptions and bias they may have initially held, how these may have changed and how many they still hold.

Engaging students actively, by using different teaching methods when exploring the concepts of cultural issues and ensuring they are constantly referred to throughout the curriculum will ensure they become an integral part of nursing care and being a nurse in a multi-cultural environment. Approaches such as that adopted by Bagnardi et al (2009) to integrate cultural competence throughout the curriculum will ensure that nurses view cultural care as 'normal' at both a conscious and sub-conscious level. As a consequence, the act of individual nurses' differentiating between 'differentness' and 'sameness' should diminish.

The approach advocated by Bagnardi et al (2009) of embedding culture into the nursing curriculum can only be positive, as it can sensitise students to the concepts of stereotyping, prejudice and discrimination and how these can affect others. It may not however, be necessarily easy to achieve. Narayanasamy and White (2004) say that the promotion of respect and tolerance for people of other cultures, will take many generations to reshape attitudes and behaviours, as its foundations are firmly rooted in attitudes, power and civic

structures. Educationalists can play a part in overcoming these barriers, by working in partnership with their students to deliver a curriculum which assists them to understand multiple factors and complexities including history, politics and the social and economic influences experienced by people from different cultures. Therefore, cultural issues need to be integrated into all nursing curricula as a fundamental part of every subject being taught.

For nurses new into the profession the advantage of this educational approach of integrating culture throughout the curriculum is that over time the nurses will become culturally self aware. That is they will be consciously and unconsciously aware of their own biases and ethnocentricity. As a result they will be able to manage their interactions with others in a way that ensures they do not impose their values, beliefs and patterns of behaviour on others from different cultures (Papadopoulos, 2006). On qualifying as a registered nurse they will be able to bring all they have learned together when working with others in a diverse health care environment and they may chose to share their knowledge with others (Bagnardi et al, 2009). This is one of the challenges which teachers of post registration education and adaptation programmes face as habits and practices of the nurses are already embedded from their years as working as a qualified nurse.

In an attempt to address this gap, Braithwaite and Majumdar (2006) developed and delivered a cultural competence educational programme to 76 public health nurses in their department. This consisted of a weekly two- hour session delivered over five weeks. The design of the programme was based on the five dimensions of Campinha-Bacote's (2002) model of cultural competence, which involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. The design of Braithwaite and Majumdars' (2006) programme was similar in approach to that used by Bagnardi et al (2009) when using Banks's multicultural model to design their curriculum. Each session was focused on one aspect of the model and the learning activities that needed to be undertaken were prescribed against each dimension.

The difference between Banks's (1995) model and Campinha-Bacote's (2002) model, is that Banks advocates embedding multicultural education into the nursing curriculum, by ensuring it is integrated into all aspects of the educational experience, including for example the administrative functions of the educational institution. In effect, this teaching percolates throughout the whole organisation and will be continually delivered over an extended period of time and in many different guises. In contrast the model developed by Campinha-Bacote (2002) is focused on providing a guiding framework for health care

organizations to develop and implement culturally responsive and relevant health care services. It has been suggested that the model can be used in different areas of practice including developing clinical competence in specialty areas such as psychiatric and mental health services, when conducting culturally sensitive research, during policy development, and when delivering education. The implication is that Campinha-Bacotes' (2002) model can be used for specific projects which need a focus on ensuring that what is proposed by the project is culturally relevant, rather than requiring a wholesale cultural change of the individual or organization, which is advocated by Banks.

For overseas nurses, there is a further dimension which needs to be considered. There is a requirement for educational establishments to respond appropriately to ethnically diverse students (Davidhizar et al, 1998). Each nurse should be empowered to share their diversity and select what is important from their own cultural upbringing. Moreover the educational environment has to provide a curriculum that provides a balance between maintaining the cultural identity of the student and ensuring the culturally diverse student has the necessary knowledge to succeed both academically and practically in healthcare environment. Whilst Davidhizar (ibid) acknowledges this is very difficult to achieve, it is possible to address this very delicate balance of needs. This is demonstrated by Bagnardi et al (2009) who show that if multicultural education is incorporated into the educational curriculum in a systematic and proactive way, it will facilitate success for both the student and the educational institution.

There is no doubt that the approach suggested by Bagnardi et al (2009) requires significant commitment from nurse teachers, who will need to expand their own knowledge base in order that they can confidently integrate transcultural nursing into their teaching. For the organisation to accept this approach, it requires commitment from the faculty and its staff to recognise the importance of multicultural education, which in turn can have a significant impact on the culture of the organisation itself.

In summary as the world changes, the need for training in cultural diversity is forever growing. Healthcare professionals need to know how to respond appropriately to persons from other cultures, in order to prevent a clash of cultures occurring. This will require educational institutions to be sensitive to this need and to develop curricula, which fully integrate multicultural issues throughout all aspects of the curriculum. To deliver this will require extensive professional development of the educational staff, and commitment from the faculty, but it is eminently achievable.

Further research questions

In conducting this research study, several questions have arisen which were felt by the researcher to be important. What follows are suggested areas of further research which would complement the work of this study, in order to add further both to the research literature and to our knowledge about this subject.

As stated, from the 1st February 2007, the NMC significantly increased the requirements of the International English Language Testing System for all non EU nurses who wish to apply to be entered onto the register. The impact of these changes has to be evaluated, but would be worthy of future research.

The ‘underworld’ of HCA behaviour was a fascinating finding in this study and is one that has not been extensively researched or written about. Given the comments about this group of staff in this study and the fact that it is known anecdotally that they have a large power base, it would be worth exploring how they build this status and how it effects others in the teams in which they work, as their behaviour clearly had an effect on some nurses in this study.

It was also evident from the findings of this study, that British trained nurses did not value the skills and competence of the overseas nurses. In general the views were negative and little recognition was given to the adaptation nurse. The rationale for these perceptions was not explored in this study, but they appear to be multifaceted and merit further investigation.

The focus of this and other research studies has been to explore overseas nurses’ experiences of both the adaptation programme and working in the UK. It would be of huge value to gain a more comprehensive understanding of the impact of adaptation programmes on the organisations that support such programmes, by exploring what the organisations have gained from having overseas nurses in the workforce.

There is little information in the literature to guide educational establishments on the best methods to use, both for integrating the concepts of cultural competence and culturally sensitive care into the curriculum or the best way to deliver that curriculum to multi-cultural groups of nurses. There are suggestions as to which teaching methodologies would be best suited, but this was not necessarily based on any robust research findings and is a gap that needs to be filled with robust research studies.

From the literature reviewed, little has been written to assist educational institutions, or nurse managers who support adaptation nursing programmes, in how to deal with a culturally diverse workforce. Given that global migration is occurring at an increasing rate (Schenker, 2010), the issues are going to intensify and so this deficit needs to be addressed.

Limitations of the study

The researcher of this study is aware that in presenting the findings of this research, the historical context in which the study is located has changed over the four years in which it was conducted. This period of time has seen some major changes to the adaptation programme. These include adaptation programmes now being delivered in higher education institutions and not in local healthcare establishments; as well as the need for nurses to pass an English language test at a higher pass mark. These changes, whilst important, are not felt to have exerted any influence on the findings and recommendations of this study. The reason for this is that these changes have neither impacted on nor addressed the fundamental cultural issues found in this study, the conclusion of which is to ensure all nurse curricula are re-designed to address the issues of living and working within a multicultural environment.

Burns and Grove (2006) describe an effect where the participants' knowledge of the research aims and intentions could influence their subsequent behaviour and therefore the research outcomes. This could be one shortcoming of this study, where the participants could have reported what they felt the researcher wanted to hear, rather than their actual experiences. For example, nurses from the Philippines could have chosen only to discuss pleasant experiences, because in their culture they have to demonstrate respect towards senior nurses. By discussing unpleasant experiences, they may have feared it could demonstrate that they were not grateful and were disrespectful, which could lead them to fear the loss of their jobs. However in this study both positive and negative accounts were given, which seems to demonstrate that this effect was minimal. The nurses who volunteered for the interviews may have done so because they may have had significant events to relate to the researcher. Interestingly, the issues of the unacceptable behaviour of others found by the adaptation nurses were only shared with the researcher in the very last interview conducted. The reasons for this cannot be truly established. It could have been because of the trust between the two parties, engendered by the fact that the researcher had shared with them the findings of the research study as it progressed and so they were

comfortable with what was being reported. Alternatively the last interview may have been viewed as the last opportunity to share what was really on the nurses' minds.

The findings of this study can be utilised by other adaptation programmes and other institutions that have a diverse workforce. The study raises some sensitive issues about how the overseas nurses were accepted into the workplace and how they themselves had to understand different societal values and the diversity of different ethnic groups. What has become totally clear is that nursing is more than just having clinical and theoretical knowledge, it is about social interactive skills and these vary depending on where in the world the nurse has trained. Adaptation programmes need to prepare overseas nurses for working in the UK. It has also become clear from this study that the overseas nurses' expectations of the nursing role in the UK and what they experienced in the clinical area were different. This was compounded by the lack of understanding by British nurses of the skills and knowledge of the overseas nurses and it is this gap that needs to be addressed in all nursing curricula.

Personal reflections

As this research study is nearing the end, it is the start of a whole new world for me as a researcher. Conducting this research study has been an interesting journey. I am sure some of my experiences in completing my doctoral studies are no different from that experienced by others. What follows are my personal reflections on my studies and some events which have had a significant effect on me.

I embarked on my studies with huge enthusiasm. I knew that I wanted to study adaptation nurses, which came from having worked closely with overseas nurses for several years. Given my experiences and views I knew this would be very worthwhile subject to study. I initially put together my literature review, which appeared to be fairly straight forward as I had plenty of experience in so doing, both from my daily employment and from other courses of study I had undertaken. I was very proud that by the first residential weekend I had notched up 8,000 words of the 50,000 I needed. Such confidence and assurance was soon to be tested. It quickly became clear that working at doctoral level required a much more enhanced skill set in terms of an intellectual ability to focus on analysis and synthesis. It required more accuracy and precision than I had previously encountered.

The first re-think came when I used the model/theoretical framework of Creemers (1997) to help me structure my work. This was the first big learning point. The work of others should influence your work, but you need to develop your own theoretical framework for

your own work and to do this was to become a challenge over the years of study that followed. As a consequence the 8,000 words shrunk to one paragraph! I recalled reading an article at the beginning of the course where the authors suggested that you could take several weeks to analyse an article and then not use it. At the time I thought this was a gross exaggeration, but soon had the idea that this would be the way of life as a Doctoral level student. It was not a few weeks' worth of work that I needed to delete, but several months' worth. This process of deletion and re-writing was to happen several times as my studies progressed. Interestingly, this process of constantly refining my work and the time and effort required, perhaps surprisingly, did not deter me in any way. I think I saw how, by re-looking and re-visiting my work and the literature, I was improving what I was doing. The focus of my research was becoming clearer as time went on and therefore this was a positive experience and one with which I was happy.

In designing my research study I had the dilemma as to how I was going to keep the adaptation nurses talking over a six month period, in order that the data collected was fresh and new. I got the idea of using vignettes after attending an EdD day school. One of the guest lecturers shared her experiences of working with school children and giving them an outline of a ship and asking them to draw in the details of the different rooms. The results were; that boys drew pictures that derived from such traditional male dominated views/values of the world, as football and DIY tools, whilst the girls drew pictures that represented the traditional female roles in the household such as the kitchen and the washing line. Sitting through this session, I was absolutely stunned by the powerful messages that came through from these children, from what appeared to be a very simple way of collecting data. The information the children gave was not a conscious act, but clearly demonstrated their values and beliefs that were embedded from their upbringing. Given that I wanted to understand the values and culture of adaptation nurses, this appeared to be an excellent tool for gaining information in a way that would be different from using a questionnaire, or interviewing the nurses, every month for six months. I decided that the use of vignettes for the group interviews could be the answer. The use of vignettes I felt would help stimulate debate at the sessions, as well as prevent them being repetitive. It would also give a focus for the session, as opposed to me turning up and hoping the nurses would have something interesting to tell me. I based the vignettes on the information I was gleaning from the data which had been collected during this research study. The result was that I was able to supply information in a different way during the interviews and as a consequence, obtained a rich source of information from the nurses. The vignettes worked well. I have many fond memories of the nurses laughing out loud at

what they were reading. Without any prompting they would launch into a story of their own, linked to an aspect of what they had just read. It was as though the vignette had triggered a memory and they had permission to share it with the group. The vignettes were not easy to compile, as they needed to be clearly aligned with the research. But they were fun to use and generated such a wealth of information, that as a data collection tool, I would have no hesitation in using them again.

There was one low that had a profound affect on me during my research. This was hearing that racism and bullying were occurring in the hospital in which I was working. It is something that still causes me shame. The overt nature with which some of this was displayed was really shocking to hear. It was made worse by the fact that it was after the event and there was little I could do to minimise the impact it had had on these nurses.

The highs of my study were working with the nurses during the interviews. The selfless way they gave their time to the study was incredible and I will always be indebted to them. However, the greatest moments were the laughter and self-deprecating comments of the overseas nurses, either when they were reviewing the data I had collected up to that point, or when presenting them with the vignettes. It is a personal memory I will cherish.

This is now the beginning of my journey in influencing and using all that I have learned in my studies for the benefit of others. Only recently I have had the opportunity to work with an overseas nurse who was poorly understood by her colleagues. The consequence of this poor understanding was that it made the working life of the nurse very difficult. She felt picked on and misunderstood, whilst her colleagues felt her behaviour was odd and added to their stress when working with her. By using my knowledge and experiences of studying for my EdD I was able to see the warning signs. Consequently, I was able to help the nurse and the team to see the issues from each other's perspective and worked hard to encourage and develop an awareness of each party's view of the world. The result is that the team is now a high performing one and the bickering and discontentment once palpable, has more or less dissipated. There has therefore, already been a practical benefit to my studies that has given back something to nursing. That for me has been a very satisfying outcome that has made my studies very worthwhile.

Finally, I hope you have enjoyed reading this thesis as much as I have enjoyed writing it. In addition, I also hope that in a small way, it has enhanced your understanding of the important questions it has raised. Of course, the thesis has not been able to address all the issues that have emerged during the research. However, as all good research aims to do, it

has opened the door for the further exploration of an important area that touches many peoples lives. Developing an understanding of the clash of cultures within a multi-cultural nursing context is only the beginning.

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APPENDIX 1 – LETTER AND FORMS FOR RECRUITMENT

8th November 2004

Dear Colleague

I am doing a research study across the University Hospitals of **XXXXXXXX**, looking at how the cultural needs of adaptation nurses have been managed and use this to inform the trust as how to improve its adaptation programme.

I would like to invite you to participate in a short interview about your experiences on coming to the UK and in your subsequent experience working as a nurse in the UK. All interviews will be conducted by myself, and will be confidential - they will be audio-taped, transcribed within the department by an administration secretary and the tapes destroyed following transcription. All names will be removed from the transcripts.

If you would like to take part in this study, details of which are given on the information leaflet enclosed, please complete the reply slip enclosed with this letter and return it in the envelope. The administrator (**XXXXXX XXXXX**) will then contact you to arrange a convenient time to obtain your consent conduct a short interview, which should last no more than 30 minutes.

I would like to thank you for taking time to read this letter and hope to hear from you soon. If you have any queries, please feel free to contact me on the telephone number above.

Yours sincerely

Linda Walker

Study Title: Managing the cultural needs of adaptation nurses

Please return this slip in the enclosed envelope to:
Linda Walker, XXXXXXXXXX

Thank you

I am interested in taking part in the above study and agree to Linda Walker contacting me:

I understand that I am under no obligation to take part in the study

Name:

Contact/Work Address:

.....
.....
.....

Telephone No:

Date:

APPENDIX 2 - ADAPTATION NURSE INFORMATION SHEET

(Proposed) Title of study: Managing the cultural diversity of adaptation nurses

Principal Investigator: Linda Walker

You may contact Linda Walker by **XXXXXXXXXX**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The role of the overseas nurses has been vital to the NHS in helping it to continue to deliver high quality care. The approach to adaptation programmes in the United Kingdom has been very random and there has been limited guidance as to what hospitals need to be included in these programmes. This project aims to evaluate the adaptation programme offered to you by the University Hospitals of XXXXX NHS Trust and in particular to explore the extent to which it met your cultural needs.

The study will investigate your views on what your expectations were prior to coming to the UK and whether these expectations were met or not and the reasons for these differences. It also wants to seek your views on how cultural needs can be met for future students completing the course.

What will be involved if I take part in the study?

A central component of the adaptation programme is ensuring that you are fully prepared to undertake the role of a qualified nurse in the UK. The research team wish to explore this concept further and understand how your cultural needs were met and if this was satisfactory to you.

The research team would like to conduct a short interview with you, should you agree to participate. The interview will last approximately 30 minutes and be held at a mutually convenient time and place. The interviews will be audio-taped in order that the researcher can capture exactly what is said in order to aid analysis.

Will information obtained in the study be confidential?

All information obtained during the course of the interviews will be confidential. The interviews will be transcribed but you will not be identified in any way, in any documents relating to study. You may have a copy of your interview transcript if you desire. The tape recording of the interview will be destroyed once it has been transcribed.

However you do need to be aware that as the main researcher in this study I have only ever worked in one University Teaching Hospital in England. Even though the study does not

refer to the name of this Trust and then it is possible that others reading this work will know what Trust was involved and may know the groups of nurses involved.

You need to be aware that I am a manager of the trust and have my own professional responsibilities as a nurse and therefore have a duty to inform my employer or the NMC, of any information which may be disclosed during the study which breeches organisational policy or professional codes of conduct.

What if I am harmed by the study?

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms would be available to you.'

What happens if I do not wish to participate in this study or wish to withdraw from the study?

If you do not wish to participate in this study or if you wish to withdraw from the study you may do so without justifying your decision.

6. Contact for Further Information

If you have any questions regarding the study please do not hesitate to contact Linda Walker on XXXXX

Thank you for reading this.

APPENDIX 3 - ADAPTATION NURSES CONSENT FORM

(Proposed) Study Title: Managing the cultural diversity of adaptation nurses

Researcher: Linda Walker

This form should be read in conjunction with the adaptation nurses Information Sheet.

I agree to take part in the above study as described in the adaptation nurses Information Sheet.

I understand that I may withdraw from the study at any time without justifying my decision.

I understand that all information will be treated as confidential and I may have a copy of the interview transcript if desired.

I understand medical research is covered for mishaps in the same way as for patients undergoing treatment in the NHS i.e. compensation is only available if negligence occurs.

I have read the adaptation nurses information leaflet on the above study and have had the opportunity to discuss the details withand ask any questions.

The nature and the purpose of the study to be undertaken has been explained to me and I understand what will be required if I take part in the study.

Signature of Nurse..... Date.....

(Name in BLOCK LETTERS)

.....

I confirm I have explained the nature of the research, as detailed in the adaptation nurses information sheet, in terms, which in my judgement are suited to the understanding of the respondent.

Signature of InvestigatorDate.....

(Name in BLOCK LETTERS)

.....

APPENDIX 4 – INTERVIEW GUIDE FOR THE RETROSPECTIVE GROUP INTERVIEWS

Sex:

Country of origin:

Years experienced as a qualified nurse and in which countries:

Are your family with you now?

Are you aiming to bring them over?

How many children do you have?

Tell me about your experience once you knew you had successfully secured a job in the UK but before travelling to the UK?

Tell me about your experience in the first few weeks of arriving in the UK?

Tell me your experience of the adaptation course?

Tell me about your experience of working in the UK

Were there any cultural needs that were not met?

How do you think your cultural needs were met?

APPENDIX 5 – INTERVIEW GUIDE FOR THE PROSPECTIVE GROUP INTERVIEWS

1. Same questions as for the retrospective group
2. What is nursing like at home in comparison to the UK?
Why come to the UK?
3. Awareness of the Professional framework?
Issues, which have arisen due to the standards?
Experience of complaints?
Own experience of academic study in the UK?
4. Clinical skills carried out in the UK as compared to home?
Communication issues encountered?

APPENDIX 6 - VIGNETTES

Group interview 5 - Clinical skills

Mary is a staff nurse who is doing her adaptation course and she is very nervous about going onto the ward for the first time. At the end of her shift she goes home and thinks about the day she has had. She feels pleased with herself that she was able to ask a doctor to write her patient up for analgesia and that the patient was very grateful. However she could not help but notice that the British nurses also required the doctors to put an intravenous cannula in, which was something Mary felt was a very basic skill and yet the nurses did not carry it out.

What examples have you come across where you felt your clinical skills were better than those of a UK nurse?

What skills did you find you were not able to carry out and why?

Have you experienced any issues relating to the carrying out of clinical skills?

Group interview 6 – Communication

Jo is a staff nurse coming to the end of his adaptation programme and he feels really pleased with his progress, as he has nearly completed all of his competencies. He is now feeling confident in answering the telephone and approaching the Doctors. However his mentor has just left the ward to work somewhere else. Jo starts to feel very anxious as his mentor often spent a lot of time with him discussing the differences in the meanings of different words, which are used in every day practice. Also as the hospital had many patients from many different ethnic groups, Jo was starting to understand about the different cultural differences of patients and their families and how they vary. Jo is now concerned that a new mentor will not be so patient with him and that he could fail his course.

What was your experience of managing to communicate with others when you first started the course?

What experiences have you had in nursing patients from other cultures where your communication styles were different?

Have you personally encountered any communication problems with others?

APPENDIX 7 - GLOSSARY

Blanket bath – The method by which a patient is washed when they are bed bound i.e. a bath in amongst the blankets (and sheets).

Cannulation – A tube (using a needle) is put into a vein in order that drugs or fluid (a drip) can be given.

Careflow™ meters for NG feeding – Trademark name of a machine, which delivers a set amount of liquid food through a tube that has been inserted through a patient's nose down their food pipe until the tip of the tube reaches the patient's stomach (NG Tube).

Care plans – These are documents which state what care a patient is to receive and when. Following any care intervention, that care is evaluated and documented, in order to ensure good communication between the nursing team.

Diathermy machine – A machine used in an operating theatre that passes an electrical current through an instrument that heats up and is used to seal bleeding blood vessels.

'Doing the backs' – A process whereby nurses go from bed bound patient to bed bound patient and move them in the bed in order to relieve the pressure from areas of the body susceptible to pressure damage. Usually this is the 'back' of the patients body i.e. bottom, heels, and shoulder blades.

'Doing the obs' – A process whereby a nurse goes round the patients and conducts measurements of their 'observations' such as temperature, pulse, blood pressure and respiration rate.

IV therapy/IV administration – IV stands for intravenous. This is where drugs and fluid are given via a vein.

Latex policy – This is a document that is drawn up by an organisation, which explicitly states how to manage a person who presents with an allergy to latex.

Male catheterisation – A tube that is passed up the penis into the bladder.

MRSA – Methicillin Resistant Staphylococcus Aureus - A bacteria that is resistant to treatment from many antibiotics (known in the press as a super bug).

NMC PIN Number – A number given to a registered nurse by the Nursing and Midwifery Council which denotes the nurse is registered with them and eligible/licensed to work as a registered nurse in the UK.

Off duty – A work rota, which indicates the day and time of the shifts .that one works or has time off.

PCA – Stands for Patient Controlled Analgesia – This is where pain killers are drawn up into a syringe and attached to the pump. The other end is attached to the patient via a cannula, which is in a vein. The patient can control the amount of pain killer they get by pressing (or not) a button attached to the machine.

Sphyg – Short for Sphygnomanometer, which is a machine, used to measure blood pressure.

Venepuncture – Inserting a device into a vein i.e. a needle or cannula.

Vac therapy – A special wound dressing that has a vacuum pump attached.