PHILIPPINE NURSE MIGRATION TO THE CANADIAN PRAIRIES:

CHALLENGES AND OPPORTUNITIES

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Abstract

Internationally Educated Nurses (IENs) from the Philippines comprise the highest proportion of IENs working as regulated nurses in Canada, yet many report challenges integrating into the Canadian nursing workforce. The purpose of this mixed methods study was to explore and describe the integration of Registered Nurses (RNs) from the Philippines into the nursing workforce in the Canadian Prairies. A total of 182 IENs from the Philippines who had migrated to Manitoba, Saskatchewan or Alberta between 2008 and 2013 participated. Data were collected through an online survey comprised primarily of fixed response questions and through semi-structured interviews.

The findings of the mixed analysis revealed that participants identified four main reasons for migrating to Canada and the Prairie Provinces. These included the presence of family in Canada, the demand for nurses in the Prairie Provinces, ease of migration, and the opportunity for a better life. Upon entry into Canada, IENs encountered challenges in both the pre-licensure and post-employment phases. Financial constraints, obtaining the necessary English language proficiency levels, and meeting the RN licensure requirements were the key pre-licensure challenges identified. Post-employment, IENs reported challenges with language and sociocultural communication, obtaining the required knowledge and skills, adjusting to different resources, conflicting values, and professional and collaborative practice.

IENs from the Philippines were employed in the Prairie nursing workforce as RNs, Licensed Practical Nurses (LPNs), and unregulated health workers (URHWs). IENs pursued LPN practice as a *Stepping Stone, Parallel Process, or Alternate Career Path*, to RN practice. The main reason cited for working as a URHW was the need to find a *survival job* while working through the nursing licensure process.

Nursing workforce integration was a complex process and the cultural, financial, and social capital the IEN possessed, along with the availability of the host country programs and supports, were important resources to facilitate the process.

Key Words:

Internationally Educated Nurses

Workforce Integration

Migration

Canada

Philippines

Mixed Methods

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Table of Contents

Figures

Tables

Chapter One: Introduction

"The XXI Century is the century of human mobility and migration. We can no longer think about our economies, societies or cultures without thinking about human mobility"

L. Thompson (2014), Deputy Director General,
International Organization for Migration

In 2015, the number of international migrants, individuals living in a country other than the country of their birth, reached 244 million; a 41% increase since the year 2000 (United Nations, Department of Economic and Social Affairs, Population Division, 2016). Amongst international migrants, an estimated 150 million are migrant workers (International Labour Organization, 2015). Canada is a country built on immigration. Currently one in five people in the Canadian population are foreign born and over 2/3^{rds} (69%) of net labour force growth has been attributed to migrant workers (Gupta, 2016). Canadian immigration policies encourage the migration of highly skilled workers who can contribute to the Canadian economy and are able to address specific labour market needs (Gogia & Slade, 2011).

While Canada's immigration strategy assumes that the immigrant's skill and knowledge, acquired through formal education and experience in their home countries, will translate into productive labour market participation in Canada, the findings of several research studies that examined the labour market outcomes of foreign educated professionals contradict this assumption (Grant, 2005; Grant, & Nadin, 2007; Picot, Hou, & Coulombe, 2007; Reitz, 2001). For many immigrant professionals, the education and work experience they were awarded points for in their immigration application did not readily translate into employment in their chosen profession (Grant, 2005; Picot et al., 2007; Reitz, 2001). A 2010 Statistics Canada report concluded that foreign educated immigrants with fields of study that typically lead to regulated professions were less likely to work in these occupations as compared to the Canadian born. The problem was further compounded for foreign educated professionals emigrating from a developing country, who were even less likely to work in their regulated professions as compared to those educated in English speaking countries. For example, only 19% of immigrants who studied a regulated occupation in the Philippines were able to find work in their associated regulated profession in Canada (Zietsma, 2010).

Health professionals, particularly Registered Nurses (RNs) comprise an important proportion of the global migrant workforce, as each year qualified nurses cross international

borders in search of higher wages, better working conditions, professional development, adventure, or an increased quality of life (Kingma, 2008a). As a result of this mobility, internationally educated nurses (IENs) have become an important source of supply of professional nurses for many countries around the world. In Canada, recent statistics from the Canadian Institute of Health Information (CIHI) revealed that in 2016 there were 33,789 IENs practicing in Canada, which represented 8.1% of the total population of regulated nurses (CIHI, 2017). However, not all IENs are successful in entering the nursing profession in Canada. A (2010) Statistics Canada report noted that only 56% of IENs reported that they were employed in their associated profession (Zietsma, 2010). If IENs are to contribute fully to nursing workforces of destination countries, the expeditious licensure and integration of IENs is essential (Jeans, Hadley, Green, & Da Prat, 2005).

Background

The Philippines is a major source country for nurses who migrate around the world (Choy, 1998; Choy, 2003). Each year in the Philippines, more Registered Nurses (RNs) than can be employed domestically are educated with the specific purpose of supplying the international market (Armstrong, 2003; Lorenzo, Galvez-Tan, Icamina, & Javier, 2007). While employment abroad affords individual nurses with an opportunity to earn higher salaries and improve their quality of life, nurses are leaving the Philippines in such high numbers that experts warn the quality of health care in the country is eroding (Lorenzo et al., 2007; Overland, 2005).

Excessive loss of qualified nurses can contribute to a brain drain of young as well as experienced workers which can result in a depleted workforce that jeopardizes the integrity and availability of health services in the source country (Buchan, Parkin, & Sochalski, 2003; Lorenzo et al., 2007). Additionally, concerns have been raised regarding the treatment and integration of Philippine nurses overseas (Tuazon, 2009). Often there is a difference between the work expectations before migration and the actual work upon arrival in the host country (Daniel, Chamberlain, & Gordon, 2001). Insufficient recognition of credentials and the underemployment of nurses abroad is an identified issue (Kingma, 2008a; Kolawole, 2010).

Canada is a primary destination point for nurses from the Philippines. In 2016 the Canadian Institute for Health Information (CIHI) reported that IENs from the Philippines represented the largest group (34.0%) of all IENs residing in Canada (CIHI, 2016a). Since the late 1990s the number of immigrants from the Philippines has grown considerably (Kelly et al., 2012), and in recent years the migration of Philippine nurses to the three Canadian Prairie

Provinces, Alberta, Saskatchewan and Manitoba has been encouraged through a number of bilateral trade agreements. In December 2006 the Government of Saskatchewan signed a Memorandum of Understanding (MOU) with the Government of the Philippines to facilitate increased recruitment of skilled Filipino workers (Philippines Overseas Employment Agency, 2006). The governments of Manitoba and Alberta followed suit entering similar agreements with the Government of the Philippines (Government of Manitoba, 2009; Philippines Overseas Employment Agency, 2008a; Philippines Overseas Employment Agency, 2008b). By the close of 2008 the governments of all three Prairie Provinces had entered agreements to attract skilled Filipino workers as a way of addressing current and projected labour shortages ("Alberta joins four other Canadian provinces", 2008).

During this time period, all three Prairie Provinces were experiencing a significant shortage in nursing labour (CNA, 2009a). In an effort to address the shortage, governments increased enrolments in nursing education programs and a number of initiatives were undertaken to improve retention rates of existing nurses (Jeans et al., 2005). As well, government recruitment campaigns were carried out overseas. Between 2007 and 2009, Alberta Health Services, the Government of Saskatchewan and the Government of Manitoba all carried out separate nursing recruitment campaigns in the Philippines that resulted in the hiring of several hundred Philippine nurses (Armitage & Suter, 2010; Government of Saskatchewan, 2008; Government of Manitoba, 2009). The provincial governments' commitment to immigration coupled with the overseas recruitment initiatives in the Philippines has moved the issue of nurse migration up on the policy agenda (Health Canada, 2009).

IENs educated as Registered Nurses (RNs) in the Philippines are employed as both RNs and Licensed Practical Nurses (LPNs) in Canada (CIHI, 2016b, 2016c). In 2015 31% of IENs practising as RNs and 45% of IENs practising as LPNs were from the Philippines (Gupta, 2016). The reasons Philippine nurses choose to work as LPNs in Canada is poorly understood. Nurses from the Philippines are educated at the baccalaureate level and are eligible to apply for Licensure as RNs in Canada. Thus, their reasons for choosing to work as LPNs are not immediately apparent and to date are relatively unexplored in the literature.

Not all IENs are successful in re-establishing their nursing careers in Canada (Kolawale, 2010). A number who have not re-entered the nursing profession, seek employment in the unregulated health workforce as health care aides or home support workers (Baumann, Blythe, Rheaume, & McIntosh, 2006; Bourgeault, Atanackovic, Lebrun, Parpia, Rachid, Winkup, Denton & McHale, 2009). The failure of IENs to re-establish their nursing careers in Canada

has important implications for the loss of valuable human capital (Kolawale, 2009) yet a paucity of research in this area currently exists.

The Purpose of the Research

IENs have the potential to add to the overall supply of nurses in Canada's Prairie Provinces. To realize this potential the integration of IENs into the nursing workforce needs to be better understood. To date very little primary research has been conducted in Canada on Philippine nurse migration and no research studies have been conducted examining Philippine nurse migration to the three Prairie Provinces. Furthermore, the reasons RNs from the Philippines choose to work as RNs, LPNs or URHWs upon migration to the Prairie Provinces has not previously been explored. The reasons for migration, and the challenges and supports utilized while re-establishing their nursing careers in Canada are currently poorly understood. Effective policies to assist nurses from the Philippines to integrate into the Canadian workforce are essential and research is needed to inform policy development. **Therefore, the purpose of this research study was to explore and describe the integration of Registered Nurses from the Philippines into the health workforce in the Canadian Prairie Provinces.**

The objectives of the research were as follows:

1. **Identify the factors that influenced the Philippine nurse's decision to migrate to Canada.**
2. **Describe the demographic characteristics of nurses who have migrated from the Philippines to the Prairie Provinces between 2008 and 2013.**
3. **Describe the past and current workforce profile of nurses who have migrated from the Philippines to one of the Prairie Provinces between 2008 and 2013.**
4. **Identify the factors that influenced the Philippine nurse's decision to work as a Registered Nurses (RN), Licensed Practical Nurses (LPN) or Unregulated Health Workers (URHW) in one of the three Canadian Prairie Provinces.**
5. **Describe the challenges that nurses from the Philippines encounter while entering and integrating into the nursing workforce in the Canadian Prairie Provinces.**
6. **Identify the supports that nurses from the Philippines utilize while entering and integrating into the nursing workforce in the Canadian Prairie Provinces.**

Chapter Two: Review of the Literature

In conducting this review of the literature, a comprehensive examination of the academic literature related to internationally educated nurses (IENs), as well as other internationally educated health professionals (IEHPs) was undertaken. The initial literature review began with a search of a number of databases: CINAHL, ERIC, PubMed and Science Direct.
Additional references were located through the citations and reference lists of key articles, books and relevant policy documents. The review included literature from a range of disciplines including nursing, sociology, anthropology, geography, human resources, political science, and history. In addition, relevant policy documents developed by governments and international or national organizations over the past twenty years were examined.

The resulting review of the literature has been organized into three main sections. In the first section, relevant literature describing the context of nurse migration will be discussed. The second section will examine the decision to migrate and in the final section of the chapter, the research on health workforce integration of IENs will be reviewed. In all three sections, the literature relating to Philippine nurse migration will be emphasized.

Section One: The Context of Nurse Migration

The concept of nurse migration is complex and examining the historical, political, social, and economic context surrounding migration and the decision to migrate can add significantly to our understanding (Freeman et al., 2012). The following section will present an overview of the history of Philippine nurse migration, Philippine migration to Canada, Canadian immigration policy, and the ethical implications of international nurse migration. To conclude, a discussion on the nursing workforce in Canada will be highlighted.

The history of Philippine nurse migration. The Philippines has a long history of colonial rule that began with the Spanish occupation in 1565 and ended with emancipation from the United States (U.S.) in 1946 (Agoncillo, 1990; Francia, 2010). During the Spanish occupation, hospital care for the sick was primarily delivered by friars and priests. It was not until U.S. colonial rule began in 1898 that nursing was introduced in the Philippines (Choy, 2003). Early training of Philippine nurses was patterned after nursing training in the U.S., and from the beginning, colonial government-sponsored nursing education included the study of the English language as an integral part of the curriculum (Choy, 2003). The construction of an Americanized nursing curriculum in the Philippines has been acknowledged as one of the most significant preconditions for contemporary international nurse migration of Philippine

nurses as it created a nursing workforce with the professional credentials and English-language ability necessary to work abroad (Choy 2003).

The "Filipinization" campaign, implemented in the early 1900s, marked the beginning of international nurse migration from the Philippines. This campaign, designed to replace American colonial government officials with Filipino citizens, led to the development of study abroad programs in the U.S (Choy, 2003). From the 1910s through the 1940s, a select group of Philippine nursing graduates were provided scholarships to study at U.S. colleges and universities. Upon their return to the Philippines, many of these nurses assumed supervisory and faculty positions in Philippine hospitals and schools of nursing (Choy, 2003). Temporary migration to the U.S. had become a prelude to a "prestigious path to professional mobility" (Choy, 2003, p. 61) and was largely viewed as a desirable experience by Philippine nurses. During this time period, temporary migration predominated; only a small number of the Philippine nurses studying in the U.S. remained as permanent residents (Choy, 2003).

Following Philippine independence in 1946, Philippine nurse migration to the U.S continued through participation in the U.S. government Exchange Visitor Program (EVP). The EVP was established by the U.S. government in 1948 and provided work and study opportunities in U.S. sponsoring institutions. Participants in the EVP were issued visitor visas for a maximum of two years (Choy, 2003). Nurses from the Philippines actively participated in the EVP, and by the late 1960s Philippine nurses constituted almost 75% of exchange visitor nurses in the U.S. (Ishi, 1967, as cited in Choy, 2003). The prestige associated with work in the U.S., coupled with poor working conditions and low salaries for nurses in the Philippines, fueled Philippine nurses' desire to participate in the EVP. In addition, Filipino parents often encouraged their daughters to apply for the exchange program, as professional work in the U.S. enabled Philippine nurses to enhance their own and their family's socioeconomic status (Choy, 2003). Although exchange nurses were expected to return to the Philippines after two years, many tried to extend their stay in the U.S. (Choy, 2003). Approximately one quarter (24%) of those who did return, frustrated and disappointed with the wages, nursing facilities, and equipment available in the Philippines, planned to go back to the U.S. (Ignacio et al., 1978, as cited in Choy, 2003).

State sponsored labour export. In the 1970s, the rapid expansion of the oil rich nations of the Middle East created an unprecedented demand for Asian labour (Ball, 1996). In response to this need for workers, and in an attempt to address high unemployment, underemployment, and foreign debt problems in the Philippines, former Philippine President Ferdinand Marcos instituted a new government policy of labour export (Ball, 1996). The initial labor-export

program was intended as a temporary solution to bolster the fledging Philippine economy, but almost four decades later it remains an integral component of Philippine government policy (Ball, 1996; Lorenzo et al., 2007; Masselink, 2009).

The Philippines has emerged as a leading labour exporting country with an estimated 8.6 million Filipino people living and working overseas (Philippines Overseas Employment Administration [POEA], 2010). Remittances from overseas workers have grown from $339 million U.S. in 1977 to an estimated $30 billion U.S. in 2015 (World Bank Group, 2016). As Ball (1996) writes, "it is difficult to overstate the importance of the overseas employment industry to the Philippine economy" (p. 75). Effectively a 'culture of migration' developed, where migration became a part of life in the Philippines (Choy, 2003). Low wages, poor working conditions, and high unemployment levels in the Philippines drove nurses to seek employment overseas (Choy, 2003) and unimpeded outmigration of nurses provided greatly needed foreign currency to the national economy and reduced the pressure on the national governments to provide domestic employment opportunities (Connell, 2010). This 'safety-valve' effect (Connell, 2010) led the Philippine government to actively promote the export of Philippine nurses, and those working abroad were considered national heroes (Choy, 2003).

Since the onset of the labor-export program, the nursing sector has constituted one of the largest categories of professional workers to travel abroad (Ball, 1996; Lorenzo et al., 2007). The oil boom in the Middle East brought the construction of new hospitals and, subsequently, an increased demand for nurses in affluent Gulf States (Ball, 1996; Connell, 2010). Nurses from the Philippines migrated to Saudi Arabia, the United Arab Emirates, and, in smaller numbers, to Qatar, Oman, and Kuwait (Connell, 2010). At the same time, Philippine nurses continued their migration flow to the U.S. Changes to U.S. legislation enabled Philippine nurses to settle as permanent residents. Simultaneously American hospitals, faced with staff shortages, began the active recruitment of Philippine nurses. The Philippines soon became the largest source country of foreign trained nurses to the U.S. (Choy, 2003).

By the 1990s, a new phase of international nurse migration had begun (Connell, 2010). As Connell (2010) writes, "demand in developed countries accelerated as populations aged, domestic training programmes proved inadequate, and jobs in the health sector were more often seen as demanding, poorly paid and lowly regarded" (p. 48). Nurse migration increasingly involved governments and recruiting agencies, and migration flows emerged and contracted in response to the health human resource needs of destination countries (Connell, 2010). Demand for nurses in the United Kingdom, Japan, Australia, and Canada, among others, added these countries as key destination points for Philippine nurses (Buchan, Kingma and Lorenzo, 2005; Goode, 2009). In response to the global demand for nurses, the Philippines

increased both the production and export of nurses (Brush & Sochalski, 2007), and by the end of the 20th century the Philippines was one of the largest exporters of nursing labour worldwide (Lorenzo, et al., 2007).

Philippine nurse migration and "brain drain." While employment abroad provided individual Philippine nurses an opportunity to earn higher salaries and improve their quality of life, the excessive loss of qualified and experienced nurses contributed to a "brain drain" of young as well as experienced nurses in the Philippines (Lorenzo et al., 2007; Overland, 2005). As early as the1960s, nursing leaders voiced concerns regarding the exodus of nurses, as staff shortages, especially in rural hospitals, became apparent (Choy, 2003). Government officials appealed to nurses to remain in the Philippines (Choy, 2003), and in 1966 a government report on "brain drain" was released by the Philippines Department of Labor (Connell, 2010). The interests of nursing leaders and the Philippine government began to diverge in the early 1970s, however. With the introduction of the labour export policy, the Marcos government began to promote the increased deployment of Filipino nurses abroad (Choy, 2003). In the years that followed, the perceived benefits of labor-export, and the remittance income it generated, led to the continuation of the labor-export policy despite its impact on the domestic nursing workforce (Ball, 1996).

The desire to work abroad transformed the culture of nursing education in the Philippines (Choy, 2003). Beginning with the EVP in the 1960s and continuing through to the present day, students, motivated by potential employment opportunities abroad, have enrolled in nursing programs in the Philippines (Choy, 2003; Dimaya, McEwan, Curry, & Bradley, 2012; Lorenzo et al., 2007; Overland, 2005). For many students, the decision to enter the nursing profession has been motivated more by the promise of high paying jobs abroad, and accordingly the opportunity to improve one's economic status than by the desire to become a nurse and work in the health field (Dimaya et al., 2012; Ortiga, 2014). Additionally, given the high demand for nurses overseas, a number of Filipino doctors and dentists have elected to retrain as nurses in an attempt to improve their prospects of employment abroad (Choo, 2003; Connell, 2010; Overland, 2005).

Since the 1970s, with the specific view of supplying the international market, the Philippines has trained more nurses than could be employed domestically (Armstrong, 2003; Ball, 1996; Lorenzo et al., 2007). In response to the growing global demand for nurses, enrollment in nursing programs increased and the education sector expanded rapidly. The number of nursing programs proliferated from 16 in 1950 to some 470 nursing programs by 2010 (Choo, 2003; Masselink & Lee, 2010). Beginning in the early 2000s, limited government

oversight and inadequate enforcement of minimum standards resulted in the rapid growth of low quality nursing programs (Overland, 2005). As the number of nursing programs increased, the percentage of students passing the national board exam began to decline (Brush & Sochalski, 2007; Overland, 2005), and in 2004, the Commission on Higher Education convened a nursing-education panel to review the quality of 200 nursing programs that were already in operation but awaiting certification (Overland, 2005); 103 nursing programs were rated as "poor" and, of those, 23 were ordered, by the Philippine government, to close by the end of the academic year (Overland, 2004). The low quality of newly established programs has been attributed to inadequate facilities, overcrowded clinical sites, and decreased exposure to client care (Dimaya et al., 2012). Furthermore, experienced nursing faculty often seek employment abroad, resulting in a shortage of qualified nursing instructors to teach in the large number of nursing programs (Brush & Sochalski, 2007; Dimaya et al., 2012; Lorenzo et al., 2007).

By 2005, growing evidence on the impact of nurse migration on the Philippine health care system was being reported. Staff shortages in rural areas, increased nurse to patient ratios, loss of accreditation, and hospital closures have all been linked to the mass migration of nurses (Lorenzo et al., 2007; Overland, 2005). Foreign employer preference for more skilled and experienced nurses led to rapid staff turnover and the need for continual investment in the training of staff replacements (Lorenzo et al., 2007; Perrin, Hagopian, Sales, & Huang, 2007), and difficulty recruiting experienced nurses resulted in many vacant positions being filled by nurses with less than 12 months' work experience (Dimaya et al., 2012; Perrin et al., 2007). Paradoxically the oversupply of nursing graduates has led to high unemployment rates amongst recent graduates, compelling many to pay a buy-in fee to work, without pay, as a "nurse volunteer" in order to acquire the required clinical experience to be employed abroad (Dimaya et al., 2012).

The negative impact of nurse migration on nursing education and health human resources in the Philippines spurred a multifaceted policy debate amongst both proponents and opponents of nurse migration (Dimaya et al., 2012; Lorenzo et al., 2007). While the policy process is still unfolding, policy makers of all sectors have come to recognize the importance of managing migration in a manner from which both source and receiving countries benefit (Lorenzo et al., 2007). As Lorenzo et al. (2007) write:

> If the Philippines were able to produce and retain enough nurses to serve its own population, there would be widespread support for additional quality nurse production and migration. Attending to source country needs will . . . benefit the global health workforce and ensure improved quality of health services for all. (p. 1417)

In 2006, The Human Resources for Health Network (HRHN), composed of representatives from public and private sectors, was established to develop a National Health Human Resources Policy and Development Plan (Dimaya et al., 2012; Lorenzo et al., 2007). The HRHN accepted nurse migration as inevitable and aimed to develop policies to strengthen the nursing workforce internally to ensure the provision of high quality nursing care both at home and abroad (Dimaya et al., 2012). The programmes that followed aimed to strengthen the nursing sector through the establishment and enforcement of core nursing competencies; as well, efforts were employed to utilize the skills of nurses, unable to find work domestically or internationally, to deliver healthcare to underserved rural areas of the Philippines (Dimaya et al., 2012). Transnational responsibility for human resource development in the Philippines has also been the focus of policy discussions. 'Giving back' mechanisms, in the form of foreign investment and training support, were seen as ways to minimize the negative health workforce outcomes associated with international recruitment of Filipino nurses (Dimaya et al., 2012). Although the outcome of these initiatives has yet to be fully determined, the multisectoral and multifaceted approach that has been adopted by policymakers in the Philippines acknowledges the complexity of labor-export policy and the important role policy can play in addressing the 'brain drain' that has threatened the quality of the nursing workforce in the Philippines (Dimaya et al., 2012; Lorenzo et al., 2007).

Philippine migration to Canada. In 2010, the Philippines Overseas Employment Agency (POEA) deployed more Filipinos to Canada than to the U.S. and the United Kingdom combined (POEA, 2010), yet Canada as a destination country for Filipino immigrants is relatively recent. Prior to 1965, only 770 Filipinos were living in Canada (Toews, 2004). Early Canadian immigration policy favoured immigrants from Britain, the U.S., and Northern Europe. The presence of race-based restrictions sought to preserve the British and white character of Canada and effectively limited the entry of immigrants from China, Japan, and other countries in Asia (Gogia & Slade, 2011). However, in 1960, the *Canadian Bill of Rights* was enacted, making discrimination based on race, colour, national origin, religion, or gender illegal (Gogia & Slade, 2011). Subsequent revisions to the *Immigration Act* in 1967 removed all race-based restrictions and introduced the point system, designed to recruit skilled workers, for immigrant selection (Gogia & Slade, 2011). As a result, immigration from the Philippines increased considerably, and by 1972 the total number of Filipinos living in Canada reached 15,081 (del Rio-Laquian & Laquian, 2013; Toews, 2004).

Nurses were among the first immigrants from the Philippines to arrive in Canada. A shortage of nurses in the hospital sector prompted the active recruitment of Philippine nurses by both the government and private sectors. In the 1960s, immigration officials, along with representatives from the health authorities, traveled to the Philippines to recruit nurses and to promote immigration to Canada. As well, Canadian hospitals partnered with Canadian Pacific Airlines (CPAir) to recruit hundreds of Philippine nurses to work in Canada (Damasco, 2012). At that time, doctors, lab technicians, dentists, office workers, and other professionals were also recruited to overcome specific labour shortages (del Rio-Laquian & Laquian, 2013; McElhinny, Davidson, Catungal, Tungohan, & Coloma, 2012*).*

While early Philippine immigrants were predominantly professionals, in 1978, with the addition of the family reunification category to the *Canadian Immigration Act*, the demographic profile of Philippine immigrants to Canada changed. Under this immigration category, family members of the first wave of immigrants could be sponsored, allowing spouses, dependent children, parents, and grandparents to enter as permanent residents. Since its introduction, the family reunification program has been an important component of Canadian immigration policy for Filipinos, allowing families to immigrate together and stay together (del Rio-Laquian & Laquian, 2013). Family networks in Canada served to further attract Philippine immigrants to the country by providing information on life in Canada to family and friends in the Philippines. As well, members of the Philippine diaspora in Canada were often able to provide the required financial capital to support the reunification of family members (Kelly, Astorga-Garcia, Esguerra, & the Community Alliance for Social Justice, Toronto, 2009).

By 1983, the majority of permanent residents (54.9%) entered Canada under the Family Class, with Economic Class immigrants comprising a much smaller (27.1%) percentage of the total (Citizenship and Immigration Canada [CIC], 2007). However, in the mid-1990s, Canadian immigration policies were re-engineered and priority was given to skilled workers and other immigrants applying in the Economic Class (Gogia & Slade, 2011). The impact of these policy changes has been significant, and by 2012 the percentage of all immigrants entering in the Economic Class had risen to 62.4%, while the number of Family Class immigrants fell to 25.2%, reversing previous trends (Citizenship and Immigration Canada [CIC], 2012). For immigrants from the Asia Pacific region, more than twice the number entered as economic immigrants as compared to the family category in that same year (CIC, 2012). Changes to Canadian immigration policy have also resulted in a three-fold increase in the number of Temporary Foreign Workers (TFWs) entering Canada over the past decade

(Alboim & Cohl, 2012). Accordingly, the number of Filipinos residing in Canada as TFWs has grown rapidly, increasing from 12,491 in 2003 to 47,470 in 2012 (CIC, 2012).

Beginning in the early 1980s, Philippine migrants also began to enter Canada through the Foreign Domestic Workers Program and the succeeding Live-in Caregiver Program (LCP) (del Rio-Laquian & Laquian, 2013; McElhinny et al., 2012). The LCP targeted foreigners for employment as live-in domestic workers and enabled individuals from the Philippines, who did not qualify under other immigration classifications, to gain entry into Canada (Davidson, 2012; Eric, 2012). After two years of successful employment as a live-in caregiver, workers were eligible to apply for permanent residency, making it a desirable program for those migrants seeking long term settlement abroad (Davidson, 2012). Men and women from the Philippines comprised an estimated 78% of live-in caregivers who came to Canada between 1993 and 2006 (Spitzer & Torres, 2008), and by the late 2000s almost 40% of all Filipinos who gained immigrant status to Canada entered through the LCP (Kelly, Astorga-Garcia, Esguerra, & the Community Alliance for Social Justice, Toronto, 2012).

Since the late 1990s, the number of immigrants from the Philippines has grown considerably. Between 1999 and 2010, Filipino landings in Canada almost quadrupled (Kelly et al., 2012), and by 2011 immigrants from the Philippines were the leading country of birth amongst recent immigrants to Canada (Statistics Canada, 2013). In 2015, RNs from the Philippines comprised the largest group of internationally educated nurses in the regulated nursing workforce in Canada (CIHI, 2016a).

Canadian immigration policies. Canada's immigration policies are complex, involving both the federal and provinical governments as well as employers and individual citizens. Applicants to Canada can apply for permanent residency at the outset or seek temporary entrance through a number of different programs (Figure 1). In 2013, when data collection for the current study was carried out, there were three main classes of permanent residents, including the Economic Class, the Family Class, and the Humanitarian Class. In conjunction with the permanent resident categories, Canada also had a Temporary Foreign Worker program (Gogia & Slade, 2011).

Permanent Residence in Canada
- **Economic Class**
  - Federal Skilled Workers
  - Provincial Nominee Program
  - Canadian Experience
- **Family Class**
- **Humanitarian Class**

Temporary Residence in Canada
- Temporary Foreign Worker Program
- Live in Caregiver Program

Figure 1. Canadian Immigration Classes.

The Economic Class is comprised of a number of sub-categories. First, in the Federal Skilled Workers (FSW) category, immigrants are selected according to their ability to contribute to the Canadian economy. An applicant is assigned points that are awarded on the basis of education, work experience, age, English or French language ability, arranged employment in Canada, and the qualifications of the principal applicants' spouse (Gogia & Slade, 2011). The Federal Skilled Worker program has always been linked to labour market needs, and between 2008 and 2010 an applicant was required to have education and work experience in one of 39 priority occupations. In June 2010, the list was revised, and the number of priority occupations was reduced to 29. The revised listing continued to include both Licensed Practical Nurses and Registered Nurses as priority occupations (Gogia & Slade, 2011).

Second, in 1996 the Federal government created the Provincial Nominee Program (PNP) in response to the provincial governments' requests to have more input into immigration selection (Alboim & Cohl, 2012). Through the PNP, the provinces were able to nominate a limited number of economic immigrants to address regional labour market needs, and nominees could be from occupations that were not included on the federal government's list of priority occupations. To be considered under the PNP, applicants had to have secured employment in the province where they were applying (Gogia & Slade, 2011).

Third, in 2008 the federal government created the Canadian Experience (CE) Class. The CE Class represented a divergence from previous immigration policies that emphasized the acceptance of immigrants as permanent residents on admission to Canada. Under the CE Class, a new two-step process was introducted, where migrants first entered Canada as temporary entrants before transitioning to permanent status. This category was created to enable highly

skilled temporary foreign workers to transition to permanent residency from within Canada (Alboim & Cohl, 2012).

Finally, the Live-In Caregiver Program (LCP) was designed for foreign workers who provide care for elderly persons, children, or persons with disabilities in private homes. As the name suggested, workers had to live in the same homes where they were employed. To be eligible for the LCP, applicants had to have completed at least 12 years of schooling, possess a moderate proficiency in English or French, and have a minimum of one year relevant work experience. Similar to the CE Class, the LCP was a two-step program, first admitting entrants as temporary workers, and after accumulating 2 years (3,900 hours) of work over a four year period migrants were eligible to apply for permanent residency in Canada (Gogia & Slade, 2011).

Family Class is the second main category for immigrants to gain entrance into Canada as permanent residents. Through the Family Class, permanent residents or citizens of Canada were eligible to sponsor family members for entrance into the country. Spouses, partners, dependent children, as well as brothers, sisters, nieces, nephews, and grandchildren, under certain conditions, were eligible for sponsorship. To sponsor a family member, sponsors were required to provide financial support for a period of three to ten years, depending on the applicant's age and relationship to the sponsor (Gogia & Slade, 2011). Prior to 2012, parents and grandparents were also eligible for sponsorship; however, a backlog of applications and lengthy processing times, in some cases exceeding 4 years, resulted in a moratorium on new applications. The federal government introduced in its place a new Super Visa that permitted parents and grandparents to visit Canada for two years at a time over a ten-year period (Alboim & Cohl, 2012).

The third category for immigrants to gain entry as permanent residents was the Humanitarian Class. Refugees were admitted either through the Government-Assisted Refugee Program or through the Private Sponsorship of Refugees program. In recent years, the federal government implemented significant changes to refugee policies, and as a result, in 2012 refugees admitted to Canada formed a smaller proportion of the total immigrant population than they had in previous years (Alboim & Cohl, 2012).

While the number of immigrants admitted to Canada as permanent residents was relatively stable, rapid growth was evident in the number of TFWs admitted to Canada. In 2010, a total of 282,771 TFWs were present in the country, which represented a 180% increase compared to 2002 (Alboim & Cohl, 2012). To enter Canada as a TFW, a job offer from an employer was required. Employers were required to prove that the foreign worker was filling a labour shortage and that wages and working conditions were comparable to those provided to

Canadians working in similar positions. Once the employer's application had been approved by immigration officials, migrant workers were required to apply for a temporary work permit in their country of residence (Gogia & Slade, 2011).

Traditionally, Canada's immigration policies have been associated with nation-building, principally focused on population growth and the creation of a stronger economy (Biles, Burstein, & Frideres, 2008). To accomplish this goal, annual immigration targets are established by the federal government with the aim to admit, each year, approximately one percent of Canada's roughly 30 million total population (Gogia & Slade, 2011). The federal government's focus on accepting immigrants as permanent residents, eligible in the future for Canadian citizenship, has made Canada an attractive country for many migrants. Alboim and Cohl (2012) argue that "one of Canada'a competitive advantages is that people can be selected as permanent residents at the outset, with full rights, access to services and on track for citizenship" (p. 44). However, between 2008 and 2012, the federal government introduced an unprecedented number of changes to policies surrounding immigration, temporary entrance to Canada, and citizenship. The policy changes were introduced in response to the government's desire to create an immigration system that was more efficient, flexible, responsive, and accordingly, better able to address Canada's economic needs (Alboim & Cohl, 2012). The scope of the reforms denote a change in direction for immigration policy in Canada with a shift toward "a 'just in time' labour market strategy that favours immigrants and temporary entrants who can make a short-term economic impact" (Alboim & Cohl, 2012, p. 58). This short-term economic focus was evident in the following policies: First, the use of occupation-based screening for Foreign Skilled Workers (FSW). Second, the ever increasing number of TFWs accepted into Canada, along with accelerated processing of applications with no caps or annual targets. Third, the introduction of the Canadian Experience (CE) Class, allowing highly skilled temporary entrants to transition to permanent residency. And finally, the ability for employers to identify applicants for the Provincial Nominee Program (PNP) based on immediate labour market requirements (Alboim & Cohl, 2012).

Ethical implications of international nurse migration. The migration of IENs is not a new phenomenon, as nurses have moved around the world for over a century (Adhikari & Melia, 2015). However, nursing shortages in many high income countries in the 1990s generated a new phase of international nurse migration. Western countries, faced with high numbers of vacancies and an undersupply of local nurses, looked globally to address Health Human Resource (HHR) requirements and international nurse recruitment was increasingly seen as a solution to labour shortages in the health sector (Buchan et al. 2005). The increased

dependence of industrialized countries on international nurse recruitment to meet domestic labour market needs raised concerns globally. 'Brain drain,' resulting from the loss of knowledgeable skilled professional nurses from some of the world's poorest countries, as well as the potential exploitation of migrant nurses, in the form of unclear contracts, inadequate remuneration, or underemployment, were becoming increasingly apparent (Kingma, 2007).

In response to these concerns, a number of countries and international organizations developed and adopted standards for the ethical recruitment of health professionals (Xu & Zhang, 2005). In 2001, the Department of Health in England introduced the first country level Code of Practice. The Code was further strengthened in 2004 and outlined ethical standards for international recruitment (Buchan, 2007). National Health Service (NHS) employers were entrusted to adhere to the Code, which specified which countries should not be targeted for active recruitment and emphasized that migrants recruited from another country should receive fair and equal treatment (Buchan, 2007, 2008). Ethical recruitment practices were similarly established for Commonwealth governments though the Commonwealth Code of Practice for the International Recruitment of Health Professionals (Commonwealth Health Ministers, 2003). The Code established that recruitment of health professionals should be fair and transparent and the conditions of employment clearly outlined for migrants (Buchan, 2008). The Commonwealth Code of Practice was one of the first multilateral agreements to address the issue of ethical recruitment of health professionals yet Canada had difficulty implementing a coordinated national response (Bourgeault & Baumann, 2011). Distributed authority and the structure of the Canadian health care system meant that each of the provinces and territories had responsibility for their own HHR planning. Thus, while the Federal Ministry of Health was involved in the negotiations of the Commonwealth Code, a single national response required the support of all provincial and territorial governments to be effective (Bourgeault & Baumann, 2011).

On May 21st 2010, the Sixty-third World Health Assembly adopted the World Health Organization (WHO) Global Code of Practice on the International Recruitment of Health Personnel (WHO, 2010a). The WHO Code, global in scope, provides guidance to governments of all Member States in the ethical recruitment of health personnel. The code discourages the active recruitment of health personnel from developing countries facing critical shortages, emphasizes the importance of equal and fair treatment for migrant workers, denotes that ethical recruitment practices provide health personnel the opportunity to assess the benefits and risks associated with different employment positions in order to make informed decisions, and highlights the importance of implementing effective health workforce planning to reduce the need to recruit internationally (International Centre on Nurse Migration [ICNM], 2011; WHO

2010b). While the Code sets out guidelines and promotes voluntary practices for ethical recruitment, it is not legally binding (WHO, 2011).

The International Council of Nurses (ICN) also responded to global concerns regarding the ethical recruitment of nurses. The ICN (2007) Position Statement on Ethical Recruitment protects the individual nurse's right to migrate but denounces unethical recruitment practices that exploit nurses or place them in working conditions inconsistent with their qualifications and experience. The ICN position statement calls for effective human resources planning and development as well as effective regulatory frameworks to assess standards of nursing education and competency to ensure only qualified individuals are allowed to practice nursing. It also highlights the principles of freedom from discrimination, good faith contracting, equal pay for work of equal value, and the need for effective orientation, mentoring, and supervision for nurses (ICN, 2007).

Similarly, the Canadian Nurses Association (CNA) Position Statement on International Trade and Labour Mobility respects the right of the individual to free mobility and to work in a country of their choice, provided they possess the required knowledge, skills, and abilities for practice in that country (CNA, 2009a). In the Position Statement, the CNA took a strong stance regarding ethical recruitment. The Statement reads: "CNA supports health human resources planning strategies that lead to self-sustainability in Canada. The active recruitment of IENs from developing countries is unethical, and CNA condemns this practice. CNA encourages governments, employers, recruiters and others to respect ethical recruitment practices" (CNA, 2009a, p.2).

Ethical recruitment: The Government of Canada's response. In 2009, the Government of Canada, foreseeing the need to respond to the issue of ethical recruitment of health professionals, commissioned a discussion paper titled "Toward a Policy on Ethical Recruitment of Health Providers for Canada." The paper, prepared for the Advisory Committee on Health Delivery and Human Resources (ACHDRH), concluded that the Government of Canada and all the provincial jurisdictions support "the spirit of the WHO Code" (Working Group on Self Sufficiency, 2009, p.16) and acknowledged that a common pan-Canadian policy on ethical recruitment could encourage a more consistent approach to recruitment across all jurisdictions.

Prior to the official adoption of the WHO Code, the ACHDRH drafted a Canadian companion document that outlined key principles, consistent with the WHO code, but tailored to the Canadian context (Bourgeault & Baumann, 2011). The principles, summarized by Bourgeault and Baumann (2011), emphasized that each jurisdiction should strive for a self-

sufficient workforce; recruitment practices should include transparency, fairness, and mutuality of benefits; all aspects of employment should be without discrimination of all kind; and jurisdictions should enhance data, research, and sharing of information. Horne (2011) described Canada's approach to policy as threefold. First, to educate enough health professionals for a sustainable health care system. Second, to ensure active recruitment does not weaken other countries' health systems and to mitigate the negative effects on source countries. And finally, to provide opportunities for employment for skilled immigrants who migrate independently to Canada (Horne, 2011).

The nursing workforce in Canada. In Canada, both Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) are regulated professions. In each of the provinces, the nursing regulatory bodies have been given the delegated authority to self-regulate and to ensure the professions remain accountable to the public and to government (Canadian Nurses Association [CNA], 2015). The nursing regulatory bodies establish the criteria for licensure and nurses are not eligible to practice nursing in a particular jurisdiction until they have met the practice requirements for registration. All nurses who meet the licensure requirements are then listed on an official register with the associated regulatory body (CNA, 2015). Since the late 1990s, basic nursing education programs for RNs in all provinces and territories (outside Quebec) require a baccalaureate degree. Across Canada, LPNs have less formal education than RNs, with basic programs at the certificate or diploma level (CIHI 2010).

Scope of practice refers to the activities the RN or LPN is authorized, educated, and competent to perform and is set out in provincial and territorial legislation and regulation (CNA, 2015). The scopes of practice for LPNs and RNs have some overlap, with each profession having both unique and shared competencies. For example, both RNs and LPNs can care for clients whose health needs are less complex, more predictable, and at low risk for negative outcomes. However, as the client's health needs become more complex and more unpredictable, the RN is required to provide the full continuum of care (College of Nurses of Ontario [CNO], 2014). Each of the professions are defined as follows:

Registered Nurses:

> RNs are self-regulated health-care professionals who work autonomously and in collaboration with others to enable individuals, families, groups, communities and populations to achieve their optimal levels of health. At all stages of life, in situations of health, illness, injury and disability, RNs deliver direct health-care services, coordinate care and support clients in managing their own health. RNs contribute to the health-care system through their leadership across a wide range of settings in practice, education, administration, research and policy. (CNA, 2015, p. 5)

Licensed Practical Nurses:

> Licensed Practical Nurses (LPNs) work independently or in collaboration with other members of the health team. LPNs assess clients and work in health promotion and illness prevention. They assess, plan, implement and evaluate care for clients. (CIHI, 2017, p. 7)

The nursing workforce in Canada is also comprised of unregulated health workers (URHWs) who support nursing care and function under the direction of a regulated nurse. URHWs do not have a defined scope of practice and are not licensed by a regulatory body (College of Registered Nurses of Manitoba, 2010). In addition, the educational requirements for URHWs vary widely between provinces and amongst individual employers, ranging from "on the job" training to a post-secondary education certificate.

The supply of regulated nurses. In the first decade of the 21st Century, Canada, like many other Western countries, faced a critical nursing shortage. The number of graduates from RN entry to practice programs had been steadily declining, and while approximately 9000 nursing students had graduated in 1990, by the year 2000 this number had decreased to fewer than 5000 (Canadian Association of Schools of Nursing [CASN], 2015). In 2002, the CNA predicted that, if current trends continued, Canada would experience a shortage of more than 113,000 RNs by 2016 (Canadian Nurses Association [CNA], 2002). In response to concerns over the adequacy of HHRs, the First Ministers of the provincial, territorial, and federal governments negotiated the 2003 *Accord on Health Care Renewal*. The Accord acknowledged that improving HHR planning in Canada was key to ensuring an adequate supply of qualified health providers, and, it highlighted, the importance of undertaking collaborative strategies to promote the education, recruitment, and retention of health professionals (Canadian Intergovernmental Conference Secretariat, 2003, p.6). At that time, the federal government committed ongoing funding to HHR renewal, and in 2004 a HHR plan was created that recognized the need to increase the supply of health professionals in Canada (CNA, 2009b). To address the decline in domestic supply, enrolments in entry level nursing programs were increased, and by 2008 the number of graduates had returned to 1990 levels. By 2014, the number had risen to almost 12,000 (CASN, 2015). Data from the Canadian Institute of Health Information (CIHI) has shown a corresponding increase in the number of Registered Nurses who are employed in Canada, with a rise from 232,566 practicing RNs in the year 2000 to a total of 296,731 practicing RNs by 2015 (CIHI, 2016d). Furthermore, the supply of LPNs in the nursing workforce in Canada has also increased. From 2006 to 2015, the number of LPNs rose from 74,968 to 113,367, a cumulative growth rate of 51.2% (CIHI,

2016d). In total, the supply of all regulated nurses has grown by 18.5% since 2006 (CIHI, 2016d).

Despite the growth in the domestic supply of nurses, concerns of a nursing shortage persist. The ageing of the Canadian population and associated increases in chronic disease care continue to place demands on the healthcare system. As well, the proportion of regulated nurses aged 55 and older increased from 21.4% in 2006 to 23.2% in 2015 (CIHI, 2016d), raising concerns about the number of nurses eligible for retirement. Finally, the proportion of regulated nurses working in rural and remote areas has declined in the past 10 years, which has led to significant discrepancies in the availability of regulated nurses between urban and rural regions of Canada (CIHI, 2016d).

IENs and the regulated nursing workforce in Canada. IENs comprise a vital and growing component of the nursing workforce in Canada. In 2006, IENs made up 7.9% (19,887) of the RN workforce. By 2015, this number had risen to 9.0% (26,459) of the RN workforce. Amongst LPNs, the growth in the number of IENs has been even greater. In 2006, IENs comprised 2.5% (1,231) of the LPN workforce, and by 2015 this number had risen to 5.1% (5,712) of the LPN workforce in Canada (CIHI, 2010; Gupta, 2016). Amongst both the LPN and RN professions, the annual growth between 2006 and 2015 has been greater amongst IENs (2.2% RNs; 16.9% LPNs) than amongst Canadian educated nurses (0.9% RN; 7.7% LPNs) (Gupta, 2016).

In each of the three Canadian Prairie Provinces, active recruitment campaigns were carried out in 2008 and 2009 in response to a critical shortage of RNs. The campaigns resulted in the recruitment of several hundred IENs, predominantly from the Philippines (Armitage & Suter, 2010; Government of Manitoba, 2009; Government of Saskatchewan, 2008). Migration has continued independent of active recruitment drives, and in 2015 the proportion of IENs practicing as LPNs was higher than the percentages nationally. A total of 6.1% of the LPN population in Alberta, 8.5% in Saskatchewan, and 10.1% in Manitoba were IENs. Amongst RNs, the proportions of IENs in Alberta (9.5%) and Manitoba (9.5%) were just above the national average, while Saskatchewan (7.9%) was slightly below Canadian levels (Gupta, 2016).

Nurses from the Philippines are educated at the Baccalaureate level and eligible to apply for RN licensure in Canada. Therefore, the reasons RNs from the Philippines choose to gain registration as a LPN in Canada are not immediately apparent and, to date, unexplored by researchers. One explanation briefly discussed in the literature is that IENs may choose to apply for licensure as LPNs if their qualifications are not considered equivalent to RN

education in Canada (Baumann et al., 2006; Taylor et al., 2011). Another possible explanation, proposed by Bourgeault (2007), suggests having two different levels of regulatory status, RNs and LPNs, enables a possible two-step process for integration of IENs into the nursing workforce: "Having a lower initial entry point – or perhaps stated more positively as a two-step process – would enable internationally trained health professionals to gain important Canadian experience while at the same time honing their skills and being gainfully employed" (p. 99). There is currently no evidence that a two-step process is occurring, however. No data currently exists to support the premise that LPNs continue on to the "next step" to attain licensure as RNs or, if in fact, they intend to continue on to become RNs. Furthermore, no studies have examined if IENs who fail to complete the registration process as a RN subsequently apply for licensure as a LPN. Research is needed to gain a better understanding of this developing trend.

IENs in the unregulated nursing workforce in Canada. Upon migration, not all IENs re-enter the nursing workforce in Canada (Kolawale, 2010). When migrants with specific skills cannot exercise them, as a result of insufficient recognition of credentials and subsequent underemployment, 'skill loss' or 'brain waste' occurs (Connell, 2010). Bourgeault et al. (2010) examined the issue of 'brain waste' in internationally educated health professionals in Canada. The researchers conducted interviews with 67 internationally educated medical graduates (IMGs), 39 internationally trained midwives, and 70 IENs in British Columbia, Manitoba, Ontario, and Quebec. A number of barriers to professional licensure in Canada were identified. Acquiring profession specific language skills, financial difficulties related to the requirements for licensure, and the length and bureaucratic nature of the process were all identified as challenges. The authors concluded that a direct consequence of these barriers for many Internationally Educated Health Professionals (IEHP) was downward professional mobility. These findings were consistent with an earlier study by Baumann et al. (2006) who explored barriers confronting IENs seeking professional nursing status in Ontario. The results of individual and focus group interviews with 39 IENs in Ontario, Canada suggested that some IENs abandon or delay their nursing careers because of short term financial challenges or simply to give them time to adjust to life in Canada.

Although accurate statistics are unavailable, a number of IENs, who have not re-entered the nursing profession, seek employment in the unregulated health workforce as health care aides or home support workers (Baumann et al., 2006; Bourgeault et al., 2009). Bourgeault (2009) examined the role of immigrant care workers in the long term care sector. The results of this study revealed that over 40% of the immigrant care workers in long term care had

trained as nurses in their country of origin. Employers noted that many immigrant care workers had strong skill sets and were overqualified for their positions as care aides in Canada. Of those, only a small number had pursued professional registration in Canada.

The issue of "deprofessionalization" and "mismatched skills" as it relates specifically to Filipino professionals who migrated to Canada was explored by Kelly et al. (2009). The researchers first surveyed 421 Philippine-educated immigrants in Toronto, Ontario, followed by two sets of focus group interviews. The first set of focus group interviews was conducted with immigrant professionals: physiotherapists, nurses, accountants, and engineers. The researchers concluded that there were a number of key issues that contributed to the downward mobility of Filipino immigrants in Canada. The first concerns the Philippines as a country of origin (Kelly et al., 2009). The authors wrote:

> Given the class structure of Philippine society, the class origins of most Filipino immigrants, and the place of the Philippines in the global economic order, Filipinos generally arrive in Canada without significant financial assets, and this situation affects their integration into the labour market. In most cases, they need a "survival job" and cannot afford educational upgrading. The continued responsibilities of Filipino immigrants and "pre-immigrant" caregivers towards their families in the Philippines further accentuates this pattern. (Kelly et al., 2009, p ii)

The second set of issues arose from the immigration programs used by Filipino immigrants to enter Canada. The high usage of the Live-in Caregiver Program (LCP) and family reunification categories meant that a large proportion of Filipino immigrants were separated from their immediate families for a significant period of time, making the obligation to send remittances to family in the Philippines almost a universal experience and adding significantly to their financial burden. Amongst IENs who entered Canada through the LCP, a few participants succeeded in becoming nurses in Canada. The vast majority however, were still working as caregivers, housekeepers, personal support workers, or aide/assistant positions in the health sector (Kelly et al., 2009).

The third set of issues raised by Kelly et al. (2009) concerned challenges with the credential assessment process and subsequent access to their professions. The authors noted that:

> Many respondents complained about the arbitrary and often ill-informed nature of the decisions made by professional regulatory bodies in relation to Philippine education and professional training. In particular, assessors appear to be ignorant of the quality of certain colleges and universities in the Philippines and the rigour of the country's professional board exams. (p. ii)

The loss of human capital that occurs when IENs are unable to re-enter a regulated nursing profession and fully utilize their education and experience in the destination country represents a significant ethical challenge (Kolawole, 2009). Significant discussion surrounding the ethical recruitment of IENs and policies to minimize brain drain have been developed globally (ICN, 2007; WHO, 2010b), yet the issue of brain waste remains poorly understood (Kolawole, 2009). Policies to support the workforce integration of IENs already residing in Canada are required (Kolawole, 2010), and additional research is needed to inform policy development (Salami & Nelson, 2014).

Section Two: The Decision to Migrate

Scholars from many of the social sciences have turned their attention to the study of international migration in recent years (Brettell & Hollifield, 2015). Historians, anthropologists, sociologists, economists, political scientists, and geographers have all theorized about international migration, articulating a number of differing and, at times, competing theoretical perspectives (Bretell, 2015; Chiswick, 2008; Diner, 2008; Hardwick, 2015; Heisler, 2008; Hollifield, 2008; Hollifield & Wong, 2015). Often the focus of inquiry and the levels and units of analysis differ within and across disciplines (Brettell & Hollifield, 2015). While some theories focus on the issue of migration from a macro level, examining structural conditions that shape migration flows, others have focused on micro level analysis, examining how larger forces influence the decisions and experiences of individuals and families (Brettell & Hollifield, 2015).

The push-pull theory of migration. Neoclassical theory has played a central role in migration research (Castles & Miller, 2009). First introduced by Ravenstein in the nineteenth century, the neoclassical perspective links migration to a combination of 'push – pull' factors (Castles & Miller, 2009). Push factors are forces in the country of origin that drive individuals to migrate, while pull factors attract migrants to destination countries (Alonso-Garbayo & Maben, 2009; Castles & Miller, 2009). When both push and pull forces are present, migration is more likely to occur (Kline, 2003). As Buchan et al. (2003) explain:

> To a certain extent there is a mirror image of push and pull factors, related to the relative level of pay, career prospects, working conditions and working environment available in the source and destination country. Where the relative gap (or perceived gap) is significant, then the pull of the destination will be felt. (p. 2)

Factors contributing to the migration patterns of nurses have been described in much of the published literature in terms of 'push' and 'pull' factors (Alonso-Garbayo & Maben, 2009; Baumann, Blythe, Kolotylo, & Underwood, 2004; Buchan & Calman, 2004; Dussault, Fronteira, & Cabral, 2009; Kingma, 2001; Kline, 2003; Leone, Conceição & Dussault, 2013; Moyce, Lash, & Siantz, 2016; Ronquillo, Boschma, Wong, & Quiney, 2011). Higher salaries, opportunities for professional development, and safer working environments draw or pull nurses toward high-income countries (Baumann et al., 2004; Hawkes, Kolenko, Shockness, & Diwaker 2009; Hendel & Kagan, 2011; Kingma, 2007; Leone, Conceição & Dussault, 2013). Conversely, poor working conditions, lack of professional development opportunities, lack of involvement in decision making, and low wages are considered push factors. Job dissatisfaction related to poor physical and organizational infrastructures, lack of respect from physicians and supervisors, and an underutilization of their nursing knowledge are also considered push factors (Buchan & Calman, 2004; El-Jardali et al., 2011; Hendel & Kagan, 2011; Kline, 2003; Zander, Blümel, & Busse, 2013).

A number of research studies have examined the push and pull factors leading to Philippine nurse migration. Respondents in earlier studies cite inadequate salaries in the Philippines; lack of compensation for shift work, holidays, and overtime; poor working conditions; favouritism in employment and promotion; inadequate education; lack of leadership; and rapid staff turnover as factors that pushed them to migrate (Choy, 2003; Lopez, 1990; Pablico, 1972). At the same time higher salaries, educational opportunities, and better working conditions pulled nurses toward the U.S. (Choy, 2003; Lopez, 1990). More recent studies show remarkably similar responses. Alonso-Garbayo and Maben (2009) interviewed 15 Philippine nurses who had migrated to the United Kingdom (U.K.). Participant narratives revealed a number of economic and professional push and pull factors influencing their decision to emigrate. Low salaries, high unemployment among nurses in the Philippines, lack of opportunities for professional development, lack of clinical resources, and poorly equipped facilities pushed nurses to emigrate. At the same time, higher salaries, employment opportunities overseas, professional development opportunities, and a practice environment with higher standards of care pulled nurses towards the U.K.

Yumol (2009) conducted a phenomenological study examining factors that prompted IENs from the Philippines to seek employment in the U.S. Unemployment, low wages, high patient to nurse ratios, and a bleak future for nursing in the Philippines were cited as reasons for leaving. Similarly Lin (2009) conducted a grounded theory study of Philippine nurses in the U.S. Study findings suggest that poor economic and social conditions, inadequate medical resources, high workloads, and poor working conditions were all factors that led to the

migration of nurses from the Philippines. Additionally, it was difficult to find employment as a nurse in the Philippines, often requiring new graduates to work as volunteer nurses, without pay, in order to acquire the necessary work experience (Lin, 2009).

Similar push and pull factors have been reported among Philippine nurses who migrate to Canada. Poor working conditions for nurses, lack of financial stability, and dissatisfaction with living conditions in the Philippines were important push factors, while better working conditions, improved standard of living, and potential for professional advancement pulled nurses toward Canada (Ronquillo, 2012; Ronquillo et al., 2011). Additionally, a 2011 study by Higginbottom cited the search for better economic opportunities, as well as the desire to learn new skills, widen their work experience, or gain access to further educational opportunities as motivating factors attracting IENs to Western Canada (Higginbottom, 2011).

The remarkable consistency in the push-pull factors identified by nurse migrants over time attests to the significant contribution this perspective has provided to our understanding of the underlying motivations that promote migration. However, the push-pull theory alone cannot fully explain the complex reasons nurses migrate. The neoclassical perspective emphasizes the individual decision to migrate, yet migration is rarely a simple individual action. Families, households, and even communities often influence migration decisions, and governments' impact migration through immigration and labour market policies (Castles & Miller, 2009). Additionally, considering migration decisions solely from the push-pull perspective does not fully explain why nurses choose to migrate to one country over another or the reason nurses decide to migrate in a step like pattern, from one country to another, when their economic needs have already been fulfilled (Alonso-Garbayo & Maben, 2009; Castles & Miller, 2009). Thus, while the push-pull theory provides important insight into nurse migration, it is important to consider these factors alongside the micro, meso, and macro structural factors that impact migration flows.

Migration systems theory. Migration systems theory suggests that migratory movements usually arise from existing linkages between source and destination countries that stem from early colonial ties, political agreements, trade partnerships, or cultural connections. Migration flows are influenced by the interaction between micro, meso, and macro structures (Castles & Miller, 2009). These structures are intertwined with no clear dividing line between them, and migration decisions are considered within the context of existing factors at all three levels (Castles & Miller, 2009).

Micro-structures refer to the informal social networks, developed by migrants themselves, that link sending and receiving countries (Castles & Miller, 2009; Hollifield, 2008). Migration

networks are formed through close ties between individual migrants and family members or friends living abroad. Once initial migration patterns have been established, the flow of migrants can be sustained and perpetuated through well-established networks (Heisler, 2008; Massey, 1998). Networks become self sustaining as "each act of migration itself creates the social structure needed to sustain it. Every new migrant reduces the costs of subsequent migration for a set of friends and relatives, and some of these people are thereby induced to migrate, which further expands the set of people and ties abroad" (Massey et al., 1993, p. 449). In many cases, migration decisions are made by families, and family linkages can provide the financial, cultural, and social capital necessary to support migration (Castles & Miller, 2009). By emphasizing the role of families and social relationships in the migration decision, network-mediated migration theory introduces the cultural and social variables that must be considered alongside economic variables (Brettell, 2015). This approach provides a greater understanding of how migration streams continue even in the presence of economic or politial policies designed to constrain them (Brettell, 2015).

The role of family networks in facilitating migration to Canada was documented by Davidson (2012). Interviews and ethnographic fieldwork were conducted to explore the experiences of Filipinas who migrated to Canada in the late 1990s. Extended family members promoted migration for relatives in the Philippines by sponsoring them through the LCP and providing them work within their homes as caregivers upon arrival (Davidson, 2012). Similarly, Lin (2009) described how Filipino nurses who had migrated to the U.S. expended substantial resources to bring other family members from the Philippines to live with them. The sustained connection between migrants and their family networks back in the Philippines, particularly in the form of sending remittances to help financially support family back home, has also been identified as an important motivating factor for migration (Choy, 2003; Kelly et al., 2009; Moyce et al., 2016).

Meso-structures have increasingly been discussed in the migration literature in recent years (Castles & Miller, 2009). Meso-structures are the 'migrant institutions' that mediate between individual migrants and state level drivers of migration (Castles & Miller, 2009; Goss & Lindquist, 1995; Masselink, 2009). Private recruitment agencies, government organizations, educational institutions, and other intermediaries play a role in the migration process and can act as either helpers or exploiters of individual migrants (Castles & Miller, 2009; Masselink, 2009). The emergence of a migration industry, with a strong interest in its continuation, plays a significant role in driving migratory movements (Castles & Miller, 2009). The Philippines Overseas Employment Administration (POEA), a division within the department of Labor and Employment, is one example of a migrant institution that functions

to assist the Philippine government to manage migration flows across its borders (Masselink & Lee, 2010). Similarly, recruitment agencies control the flow of information and access to overseas opportunities for potential migrants (Masselink & Lee, 2010). Masselink and Lee (2010) also contend that Philippine nursing schools act as migrant institutions and play a role in expanding and perpetuating the migration industry:

> While schools are in a more "upstream" position in the migration process that organizations such as the POEA and recruitment agencies, they act as gatekeepers to migration opportunities, altering the material conditions of migration by opening new channels for potential migrant nurses and reinforcing the culture of migration in nursing education by linking their educational programs to subsequent phases in the migration process. (p. 168)

Finally, macro-structures are large-scale institutional factors including national policies, laws, and inter-state relationships that impact migration flows. The focus of macro level analysis is not the individual migrant but rather the national and international public policies that control or attract populations, thereby creating, shaping, and sustaining particular migration streams (Bretell, 2015). The Philippine Labor-Export Policy brought in by Former President Ferdinand Marcos is one example of a national policy designed to promote and sustain overseas migration (Ball, 1996). Similarly, the three bilateral trade agreements between the Governments of Alberta, Saskatchewan, Manitoba, and the Philippine Government (Armitage & Suter, 2010; Government of Manitoba, 2009; Government of Saskatchewan, 2008) were established to promote migration of skilled workers from the Philippines to each of the Prairie Provinces.

Push-pull theory provides important insight into factors within both the source and destination countries that may impact an individual's decision to migrate. However, migration is complex and decisions may also be influenced explicitly and subtly by networks, migration industries, and state policies (Masselink & Lee, 2010; Prescott & Nichter, 2014). The multiple theoretical perspectives espoused across disciplines highlight the complexity of the migration process. No one theory or discipline alone can fully explain international nurse migration, and a more in depth understanding is achieved by examining the issue from more than one perspective (Brettell & Hollifield, 2015; Castles & Miller, 2009).

Section Three: Workforce Integration

Bourdieu's (1986) discussion regarding 'forms of capital' provides a useful framework for examining the workforce integration of IENs. According to Bourdieu (1986), capital exists

in three fundamental guises: as cultural capital, which includes accumulated cultural knowledge, as well as the power and status that possession of such cultural knowledge confers; as social capital, made up of a durable social network; and as economic capital comprised of financial and material resources. A key feature of each form of capital is that each may be converted into the other. For example, social capital, in the form of a network, may be used to find a job and generate economic capital, or economic capital may be invested to obtain cultural capital in the form of educational credentials (Bourdieu, 1986; Friesen, 2009; Moskal, 2013).

Cultural capital: Institutionalized state. In discussing cultural capital, Bourdieu (1986) makes a distinction between the institutionalized and embodied states. Institutionalized cultural capital is obtained through the acquisition of recognized academic qualifications. Institutionalized capital confers on its holder a form of cultural capital that can be converted into economic capital through the participation in the labour market (Bourdieu, 1986). According to Bourdieu, this product of conversion of cultural capital into economic capital establishes the value of a given qualification relative to other qualification holders by determining the monetary value for which the educational credential can be exchanged on the labour market (Bourdieu, 1986).

Institutionalized capital, as with other forms of capital, is valued and given meaning according to particular social contexts (Moskal, 2013). In the case of foreign credentials, Canadian professional associations determine the worth of a particular credential through licensing and qualifications recognition processes (Girard & Bauder, 2007). The concept of institutionalized cultural capital is particularly relevant when considering the integration of IENs into the Canadian health workforce. For many IENs who migrate to Canada, the educational qualifications they possess are not considered equivalent to Canadian standards, and bridging or upgrading programs are often required in order to qualify to write licensing exams (Baumann et al., 2006; Covell, Neiterman, & Bourgeault, 2016). In essence, the institutionalized cultural capital of professional immigrants devalues with migration.

Qualifications' recognition can present an intractable barrier to employment for IENs in the destination country (Hawthorne, 2001). The findings of three separate reviews of the literature on IEN migration and integration concluded that the difficulty IENs encounter obtaining licensure and registration in the receiving country was a prevalent theme in both past and recent studies (Moyce et al., 2016; Newton, Pillay, & Higginbottom, 2012; Woodbridge & Bland, 2010). Low immediate recognition rates of credentials, required supervised practice to qualify for registration, and complex and difficult registration processes have been

identified as barriers confronting IENs seeking licensure (Gerrish & Griffith, 2004; Hawthorne, 2001; Moyce et al., 2016). Similar findings were reported by Covell et al. (2016) after conducting a scoping review of literature with a focus on the integration of IEHPs into the health workforce. A total of 407 published sources between 2000 and 2012 were reviewed, the majority focused on the integration of international medical graduates (IMGs) or IENs. The processes IEHPs undertake to meet professional regulatory body requirements, along with the barriers encountered in obtaining professional recertification, emerged as a significant challenge to workforce integration. Lack of familiarity with the regulatory system, obtaining all the necessary documentation, and the time and cost associated with registration were factors influencing the IEHPs ability to recertify.

A number of studies have examined the experiences of IENs seeking registration as a RN in Canada. Blythe, Baumann, Rhéaume, and McIntosh (2009) conducted a qualitative study exploring factors that contributed to the success and failure of IENs to re-establish professional careers in Ontario, Canada. Thirty nine IENs participated in focus groups and individual interviews. The results revealed that IENs experienced obstacles at each stage of the licensing process. Challenges were reported in navigating the regulatory system, attaining the required educational standards, and passing the licensing exam. These findings were consistent with two earlier studies. A qualitative study by Sochan and Singh (2007) explored the experiences of 12 IENs in their efforts to gain entry to practice as a RN in the province of Ontario. The participants described the credential process as inefficient, time consuming, and expensive. In addition, the 2005 report *Navigating to Become a Nurse in Canada* expressed concern regarding a protracted assessment process for IENs and jurisdictional differences amongst provincial Regulatory Bodies (Jeans et al., 2005). More recently, Taylor et al. (2011) explored the experiences of a cohort of nurses who landed in Alberta as Temporary Foreign Workers in 2008. During open ended interviews, IENs expressed concerns regarding the expense, time, and perceived cultural bias inherent in the registration process. Interviewees noted that while they were generally aware that the assessment of foreign credentials was part of the process, they were unaware that they would have to undergo a lengthy clinical competence assessment and enrol in upgrading courses if they did not meet all the required competencies for entry level practice in Canada. Participants felt the assessment process was unclear, upgrading courses were costly, and the outcomes of the assessments were at times unfair. The authors noted that nurses from the Philippines experienced particular difficulties with the registration process. Similarly, Higginbottom (2011) conducted a focused ethnography of 23 newly – recruited IENs to a health authority in Western Canada. In reporting the study findings, Higginbottom (2011) noted that, "although this study was not designed to focus on

credentialing we found this issue too persistent and troubling to avoid reporting" (p. 9). Many IENs were not informed during recruitment of the different stages, procedures, and requirements of the provincial regulatory body and questioned the consistency of licensing decisions (Higginbottom, 2011).

The findings of these studies suggest that IENs experience significant barriers that delay, or at times prevent, their entry into the Canadian workforce. Statistics reported by Provincial RN regulators confirm that many IENs fail to become licensed as RNs in Canada. In Ontario, the College of Nurses of Ontario reported that an estimated 40% of IENs failed to complete the registration process (Baumann et al., 2006). Similarly in Alberta and Saskatchewan, the regulatory bodies reported that 6792 files of IENs were closed between 2010 and 2012, as they had been inactive for more than two years (CARNA, 2011, 2012; SRNA, 2011, 2012).

Cultural capital: Embodied state. Embodied cultural capital takes years to develop. It is an integral part of the person, deeply internalized, and not consciously mastered: 'a habitus' (Bourdieu, 1986; Shim, 2012). According to Bourdieu (1990), the habitus is "a system of dispositions common to all products of the same conditioning" (p.59). Hence those individuals who are located in close proximity experience similar conditions and, therefore, are more likely to share similar perceptions and dispositions that translate into similar practices and representations (Mendoza, Kuntz, & Berger, 2012). Mendoza et al. (2012) extend Bourdieu's concept of habitus to describe the development of a 'professional habitus' in which professionals "develop shared perspectives, norms, strategies, and practices" (p. 561). These authors suggest that the professional habitus develops as a result of socialization processes that are defined by the contexts in which professionals are educated and work (Mendoza et al., 2012). It follows, therefore, that professionals from different educational and employment backgrounds are less likely to share a common habitus. These differences in dispositions and practices may result in discomfort, strangeness, and misunderstandings as intercultural contexts collide (Shim, 2012).

Two research studies exploring the integration of internationally educated engineers into the engineering workforce in Canada concluded that a shared professional habitus was an important component of workforce integration. Friesen (2009) concluded that the acquisition of cultural capital and habitus was critical to the successful adaptation of immigrant engineers into the Canadian engineering profession and noted that cultural capital and habitus were developed through immersion in the practise of professional engineering in Canada. Similarly, Girard and Bauder (2007) concluded that for internationally educated engineers in Ontario,

the "unfamiliar habitus" of the engineering profession presented an obstacle that limited access to the profession even once formal qualification requirements were met.

IENs are often unfamiliar with the culture and professional habitus of nursing practice in Canada. Internationally educated nurses have varying degrees of autonomy and assertiveness. As well, the professional nursing role, scope of practice, and the degree of patient and family involvement in care differs significantly between countries (Neiterman & Bourgeault, 2015; Tregunno, Peters, Campbell, & Gordon, 2009). Nurses in Canada have a more egalitarian relationship with physicians and are involved in independent clinical decision-making. Families and patients are often actively involved in care and participate in treatment decisions (Tregunno et al., 2009). Professional nurses are required to be accountable, autonomous, and assertive (Begley, 2010). A lack of knowledge of the culture of nursing practice in the host country can lead to misunderstandings that threaten the safety and quality of patient care (Cummins, 2009; Sherwood & Shaffer, 2014; Tregunno et al., 2009) and impact the successful integration of IENs into the workforce (Baumann et al., 2006; Lum et al., 2015.

Differences in the level of autonomy and scope of practice of nurses around the world have been discussed by a number of authors. Nichols and Campbell (2010) conducted an integrative review of the experiences of internationally recruited nurses in the U.K. between 1995 and 2007. One of the recurrent themes that emerged from the literature reviewed was the perceived difference in the role and purpose of the nurse. Internationally recruited nurses experienced culture shock on arrival to the U.K., and many were surprised with the unfamiliar nursing role and approach to patient care. A number of IENs noted that U.K. nurses practiced with greater autonomy; others found the nurses' role more restricted as they were not allowed to carry out certain technical skills that they routinely performed in their home country. The value placed on patient centred care and the nurse's role as advocate was also noted by IENs. Furthermore, IENs from the Philippines identified a different culture of nursing in the U.K. that was based on a more holistic approach rather than the curative medical model practiced in the Philippines (Nichols & Campbell, 2010). An earlier study by Gerrish and Griffith (2004) noted that IENs were often familiar with a more structured nursing hierarchy and task based approach to nursing practice. As a result, IENs had to adjust to different ways of organizing and prioritizing care and learn new ways to communicate with interdisciplinary team members as well as senior nursing and medical staff.

Similarly Troy, Wyness, and McAuliffe (2007) reported that overseas nurses in Ireland experienced difficulties assuming autonomy and control over their professional nursing practice, as their previous practice, in their home country, was often directed by physicians' endorsements. Lin (2009) found that Filipino nurses, adjusting to the U.S. health system,

needed to relearn their roles as nurses and had to be willing to think critically and act independently at work. Once nurses learned critical thinking skills and adjusted to the work environment, they enjoyed the independence and autonomy that came with being a nurse in the U.S.

IENs also reported concerns regarding the legal aspects of nursing practice in other countries. Philippine nurses in the study by Daniel et al. (2001) cited the issue of increased legal liability in the U.K., as nurses were expected to act on verbal orders from physicians instead of requiring written orders as was the practice in the Philippines. Similar concerns were raised by Philippine IENs working in the U.S. Nurses worried about the danger of lawsuits and felt that nurses in the U.S. had more legal responsibilities than nurses in the Philippines. The findings of research studies conducted in Canada were consistent with those cited above. IENs in a study by Baumann et al. (2006) indicated that nurses in Canada have more responsibility for their own practice, but also carry more liability than nurses in their home countries. Similarly, Tregunno et al. (2009) were told by study participants that nurses in Ontario, Canada "have more prestige, power [and] professional autonomy as well as an expanded scope of practice" (p. 186). IENs also noted that patients and families had more rights and were more involved in decision making than in their home countries (Tregunno et al., 2009).

The level of assertiveness expected of nurses varies globally. Lin (2009) noted that on arrival to the U.S., IENs from the Philippines did not feel comfortable speaking in the presence of doctors or patients. Philippine IENs indicated that they were more likely to simply agree with physicians and were not likely to question or clarify doctors' orders. IENS also found it difficult to delegate, especially to ancillary staff, and expressed the need to become more assertive in order to communicate more effectively with other health care providers. Likewise, Cummins (2009) described challenges with assertiveness and delegation amongst IENs working in a perioperative setting in Ireland, and Gerrish and Griffith (2004) observed that providing guidance to support staff working under their direction was initially challenging for many IENs. Either being too passive or too aggressive as well as managing team conflict can present challenges for IENs, and often these communication issues contain elements of cultural difference (Lum et al., 2015).

Linguistic capital is an important form of embodied cultural capital (Friesen, 2011). Within nursing, English language fluency is a requirement for registration in each of the Prairie Provinces. In order to become licensed, IENs must demonstrate English language competence on standardized language tests. However, within the nursing profession, command of language fluency (grammar, vocabulary, and syntax) is not sufficient to ensure communicative

effectiveness. In addition to technical language skills, IENs need to understand the socio-cultural aspects of language required in the workplace (Allan & Westwood, 2016; Duff, Wong, & Early, 2002; Lum et al., 2015). In the work setting, IENs are required to use and interpret body language, engage and respond empathetically, communicate with clients with communication impairments, navigate conflict situations, and interact with colleagues in person and by telephone. The range and complexity of the communication skills required extends well beyond technical language skills (Allan & Westwood, 2016; Duff et al., 2002; Lum et al., 2015).

Language and communication skills have been identified in a number of studies as an important factor impacting workforce integration. Jeans et al. (2005) reported that the hiring decisions of hospital employers were highly influenced by the IENs' language skills. Difficulties with language and accent have been found to impact communication with patients and colleagues (Cummins, 2009; O'Neill, 2011), and concerns regarding the real and potential risks to patient safety and quality of care have been cited (Zizzo and Xu, 2009). Almost 50% of provincial regulators stated that meeting the language requirement was the most challenging component for IENs in the application process (Jeans et al., 2005), and language difficulties have been identified as a possible factor contributing to the high rates of licensure examination failure amongst IENs (Blythe et al., 2009, Covell et al., 2016; Kolawale, 2009). O'Neill (2011) conducted semi-structured qualitative interviews with 10 IENs who had migrated to Australia. The overarching theme identified from participants' narratives was differences in cultural and professional identity. Participants described how difficulties with language and cultural understanding impacted their sense of belonging and ability to practice in a hospital setting. IENs reported challenges communicating with local nurses, and the gap between language preparation and the language skills required for clinical practice led nurses to feel unprepared and unsupported. Finally, a recent U.K. study focused on migrants moving to the U.K. from other European Union (EU) countries. The researchers conducted an online survey that included 130 nurses, followed up by telephone or face to face interviews with a small subset of participants, 13 or whom were nurses. All of the nurses had English language competence upon arrival to the U.K., but this did not guarantee the 'right' language skills to work effectively in the health system. Cultural differences with language and learning local colloquialisms were identified challenges (National Nursing Research Unit, King's College London, 2014).

Social capital. Bourdieu defines the concept of social capital as "the aggregate of the actual or potential resources which are linked to possession of a durable network of more or

less institutionalized relationships of mutual acquaintance and recognition" (Bourdieu, 1986, p. 248). For Bourdieu, the concept of social capital is instrumental, constructed by the social relationship itself, as well as the resources it creates (Portes, 1998). Social capital has been found to have an impact on the integration of immigrant professionals into the workplace (Friesen, 2011; Kelly et al., 2009). Kelly et al. (2009) surveyed 421 Philippine professionals in Toronto, Ontario and found that 47% of respondents were assisted by personal social networks in finding their current job. Kawi and Xu (2009) conducted an integrative review of facilitators and barriers encountered by IENs as they adjust to foreign work environments. The presence of social support systems and informal networks emerged as an important facilitator to successful workplace adjustment. Baumann et al. (2006) identified that the presence of relatives and/or contacts in Canada was an important facilitator for employment for IENs in Ontario. Similarly, Higginbottom (2011) noted that many IENs commented on the role played by family members, whether living in Canada or in their country of origin, helping them overcome challenges associated with living and working in a new country. Finally, Covell, Neiterman, and Bourgeault (2015) reported how access to friends, colleagues and personal contacts benefited IENs when looking for employment and when preparing for national licensure exams.

Access to information is an important resource made available through social relationships (Coleman, 1988). Social networks can act as information channels for the job related resources necessary for economic integration (Covell et al., 2015; Nakhaie & Kazemipur, 2012). Currently, little is known about how or where IENs access information and resources to assist them to navigate the licensure process. Omeri and Atkins (2002) observed that IENs frequently used informal networks and word of mouth to access information, while Jeans (2006) noted that there was no consolidated source of information for IENs migrating to Canada for work. As well, many of the resources that did exist were written in a language too complicated for IENs not fluent in English or French. As a result, Jeans (2006) concluded widespread misinformation and conflicting information exists in the IEN community in Canada.

Economic capital. Economic capital is "immediately and directly convertible into money" (Bourdieu, 1986, p. 243). It refers to the assets and financial resources of an individual (Moskal, 2013) and is required while obtaining or upgrading the necessary academic qualifications to enter the Canadian workforce. Recognizing the costs associated with migration, the Canadian government has included, as part of the immigration process, a requirement that all applicants seeking entry into Canada demonstrate access to a certain level

of financial capital. As a result, successful applicants come primarily from middle income backgrounds (Kelly et al., 2009). However, middle-class incomes vary significantly across different source countries. Consequently, immigrants often have quite different levels of financial capital upon arrival to Canada (Kelly et al., 2009). For some immigrants, even a year's salary saved and brought to Canada represents relatively little spending power in Canada (Kelly et al., 2009).

The lack of financial capital has been identified as a significant factor impeding re-entry into a regulated profession. One study by Kelly et al. (2009) found that the majority of Philippine immigrants arrived in Canada with relatively modest personal resources and assets; even a year's salary saved and brought to Canada quickly disappeared with the high cost of housing, food, and transportation. The pressure to support family members created further financial strain. Study participants were supporting family members back in the Philippines or saving to finance the reunification of their family in Canada. Additionally, the cost of required upgrading courses added further to their financial distress. The authors concluded that professional immigrants from the Philippines faced an immediate need for income and for ongoing stable employment upon arrival. As a result, they needed to seek and accept survival jobs and could not wait for jobs in the appropriate profession (Kelly et al., 2009).

The lack of financial capital has also been found to impact the IENs' decision to enter the nursing workforce. In one Ontario study, short-term financial priorities were cited as an important barrier preventing IENs from making the investment required to regain professional status (Baumann et al., 2006). Similarly, Jeans et al. (2005) reported that IENs tend to have limited financial resources and many must work in survival jobs in order to support themselves and their families throughout the registration process. McGuire and Murphy (2005) described the high cost of licensure in Alberta, noting expenses associated with English language assessments as well as application, examination, and registration fees. At the same time, IENs were faced with costs of relocation and settlement, as they established themselves and their families in a new country. The financial burden of retraining programs has also been reported. Costs associated with required upgrading or bridging courses caused some IENs with financial constraints to drop out of the credentialing process (Blythe et al., 2009; Covell et al., 2016; Sochan & Singh, 2007).

Integration: A two-way process. A central premise of Canadian immigration policy is that integration into Canadian society is not the sole responsibility of the immigrant. Integration is a two way process; immigrants commit to becoming responsible contributing citizens and participate in the integration process, and in turn the host society must ensure that

policies and programs reflect values of fairness and equality and provide opportunities for immigrants to contribute to society (Frideres, 2008). Thus, in addition to the various forms of capital that immigrants possess, successful integration is also impacted by the nature of policies and programs, as well as the attitudes of members of the host society (Frideres, 2008). Relating this premise to workforce integration, the capital the IEN holds, along with government policies supporting the integration of skilled immigrants, the regulatory policies governing licensure of IENs, the availability of programs to support registration and employment, as well as the attitudes of Canadian educated nurses toward IENs are all important factors to consider (see Figure 2). The following discussion will highlight the policies, programs, and supports in place for IENs in the three Prairie Provinces at the time the study was carried out.

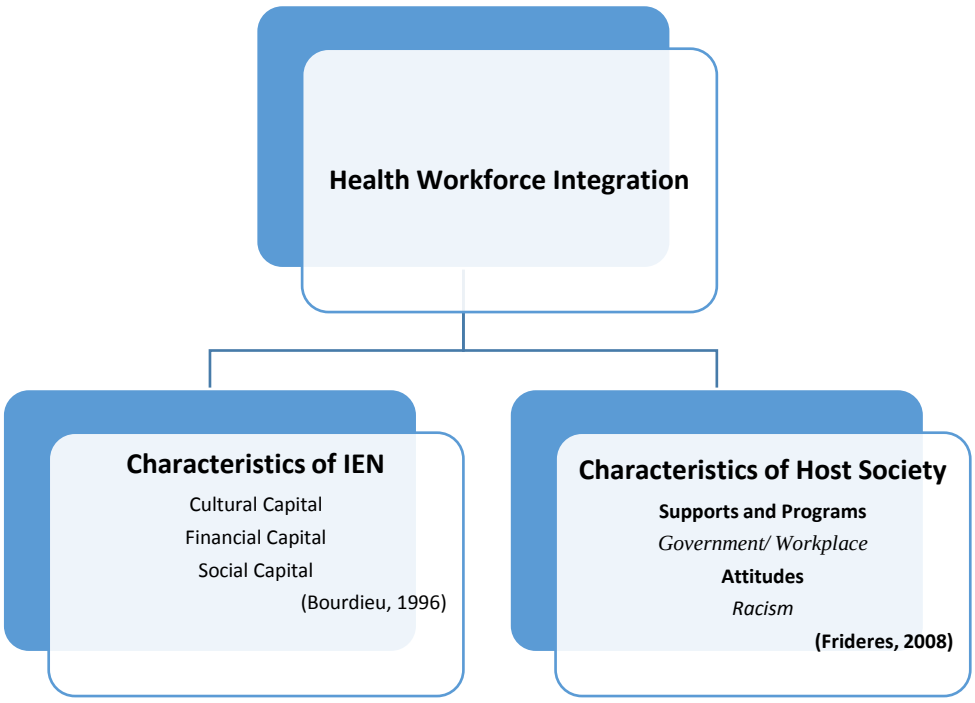

Figure 2. Health workforce integration.

Government initiatives: Internationally educated health professionals. The Canadian government's support for Internationally Educated Health professionals (IEHPs) has largely been realized through two key initiatives. Health Canada's Internationally Educated Health Professionals Initiative (IEHPI), introduced in 2005, provided funding to each of the provinces

and territories to support projects that met one of six strategic objectives: clear paths to licensure, fair and transparent assessment of credentials and competence, access to bridging and remediation programs, faculty development, workplace integration programs, and enhanced regional collaboration (Horne, 2011). Additionally Human Resources and Skills Development Canada's (HRSDC) Foreign Credential Recognition (FCR) program was initiated in 2003 and has supported the development of fair and transparent pan-Canadian processes for internationally educated workers (Horne, 2011). Over the past decade, both programs have supported a number of initiatives designed to facilitate the integration of IENs. For example, the competency assessment centres in Alberta, Manitoba, and Saskatchewan along with supports such as bridging programs and preparation courses for the Canadian Registered Nursing Exam have been funded through these initiatives (Horne, 2011).

Requirements for registration as a RN or LPN in Manitoba, Saskatchewan, and Alberta. Regulatory Colleges protect consumers by ensuring health workers meet the minimum quality and safety standards for practice in a particular regulated profession (Sherwood & Shaffer, 2014). In Canada, each province regulates nursing through legislation, delegating regulatory responsibility to professional colleges and associations (Jeans et al., 2005). Each of the regulatory bodies establishes policies, procedures, and practices for admitting nurses to the registry (Jeans et al., 2005). Manitoba, Saskatchewan, and Alberta each have separate nursing regulatory bodies for RNs and LPNs (see Appendix A). To practice as a Registered Nurse or Licensed Practical Nurse, IENs must register with one of these provincial nursing regulatory bodies (CIHI, 2017). Although some variations in policies exist across provinces and professions, all nursing regulators require evidence of English language proficiency and a qualifications assessment.

Language requirements. English language fluency was a requirement for registration in each of the Prairie Provinces. In order to become licensed, IENs must demonstrate competence in the communication skills speaking, listening, reading, and writing by achieving required scores on standardized language tests (Ogilvie, Mill, Astle, Fanning, & Opare, 2007). In 2002, the Centre of Canadian Language Benchmarks completed an occupational analysis of the nursing profession in Canada. At this time, the project benchmarked the English-language demands of the nursing profession across Canada as listening 9, writing 7, reading 8, and speaking 8 (Centre for the Canadian Language Benchmarks, 2002). In 2011, based on recommendations brought forward by the National Fluency Working Group, all RN and LPN regulators in the Prairie Provinces harmonized their English language requirements and

adopted a higher English language proficiency level, raising the required listening score to 10 (Munoz, 2013).

Across the country, language training programs were offered to assist immigrants to meet the necessary English language requirements for work in Canada. As well, a number of profession specific language programs have been developed (Red River College, 2016). However, the availability of profession specific language training has at times been limited. This led Bourgeault et al. (2010) to include the need for increased accessibility to these programs as a key policy recommendation to facilitate the integration of IEHPs into the Canadian health care system.

Qualifications assessment. The assessment of qualifications for IENs upon application to one of the nursing regulatory bodies was comprised of multiple components. Key components included the verification of documents to ensure authenticity, the verification of currency of practice, and the assessment of nursing education and experience. IENs applying for registration as a RN may also be required to complete a substantially equivalent competency assessment (SEC). The SEC, also referred to as the clinical competence assessment (CCA), assessed the IENs competence in four categories: Professional responsibility and accountability, knowledge based practice, ethical practice, and service to the public. The assessment involved a combination of self-assessment, written examinations, and practice based scenarios; a complete assessment required four and one half day days to complete (Stanhope-Goodman, Hendrickson, & Nordstrom, 2014). The results of the assessment identified gaps in knowledge and skills and assisted the regulator to determine what (if any) supplementary education was required to meet registration requirements (Hamilton, 2009). Not all IENs were referred for a SEC/CCA. An assessment was required if the regulator was unable to establish, through paper documentation alone, the applicant's ability to meet entry level nursing competencies (Stanhope-Goodman & Nordstrom, 2012). While no data on the percentage of IENs referred for assessment in Manitoba and Saskatchewan assessments was available, an estimated 75% of IENs were referred for a SEC/CCA in Alberta (Stanhope-Goodman et al., 2014).

In 2012, the College of Licensed Practical Nurses of Manitoba (CLPNM) adopted a similar approach to assess the nursing skills and knowledge of IENs (J. Breton, personal communication, February 22, 2017). A clinical competence assessment (CCA) was conducted over one to two days and assessed competence in general and/or specialty nursing knowledge, health assessment, pharmacology and medication administration, pathophysiology, knowledge of the Canadian health care system, basic and advanced clinical skills, current

technology, clinical judgement, therapeutic communication, and cultural competence. The results of the assessment were used to determine the applicant's eligibility for registration. If gaps in knowledge and skills were found, a prescribed course of study was required before proceeding with registration (CLPNM, 2012). In 2013, at the time the research study was conducted, the Saskatchewan Association of Licensed Practical Nurses (SALPN) and the College of Licensed Practical Nurses of Alberta (CLPNA) used a self-assessment process to assess the entry level competencies of IEN applicants (CLPNA, 2013; SALPN, 2013).

National registration examination. Once eligibility requirements have been met, candidates are approved to write the corresponding national examination. At the time this study was carried out, RNs wrote the Canadian Registered Nurse Examination (CRNE), and LPNs wrote the Canadian Practical Nurses Registration Examination (CPNRE). A number of studies have identified challenges encountered by IENs writing the CRNE (Blythe et al., 2009; Higginbottom, 2011; McGuire & Murphy, 2005; Taylor et al., 2011). Between 2008 and 2012, the pass rate on the CRNE was consistently lower for IENs than for Canadian educated nursing graduates (see Figure 3).

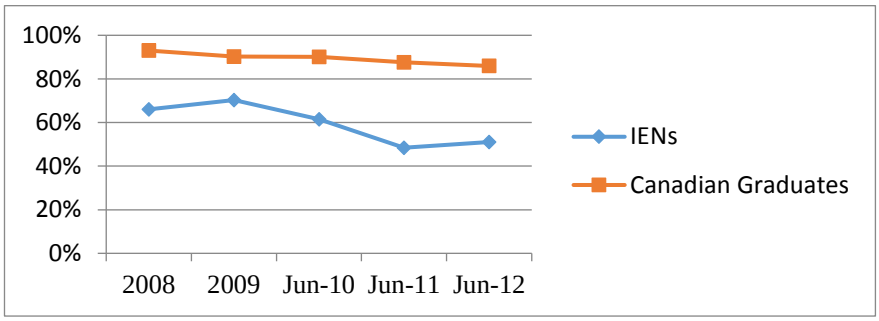

Figure 3. Comparison of CRNE pass rates for IEN and Canadian educated graduates. (CNA 2009c, 2010, 2011, 2012, 2013)

Inadequate knowledge of the culture of Canadian nursing practice, differences in the scope of practice of nurses in other countries, as well as variations in entry level nursing education curricula have been cited as possible reasons for the lower performance on the CRNE among IENs (Higginbottom, 2011; Taylor et al., 2011). In 2012, the Canadian Association of Schools of Nursing (CASN) released a report on IEN success rates for first time writers on the CRNE. The report noted that while the pass rate for IENs, as compared to Canadian-educated writers, was lower, IENs from countries with English as a first language consistently outperformed other IENs. Critical thinking questions as well as items that focused on families, groups, or

communities were areas of lower performance for IEN writers (Canadian Association of Schools of Nursing [CASN], 2012).

At the same time, CASN released a report on the performance of IENs as compared to Canadian-educated writers on the CPNRE. The analysis was conducted on data over a three year period from 2009 to 2011. The report concluded that, overall, Canadian-educated writers scored higher that IEN writers (78.2% as compared with 65.3% respectively). Similar to the CRNE report, IENs who migrated from English speaking countries outperformed other IENs and Canadian-educated writers performed better than IENs on all competency categories (CASN, 2012).

Bridging programs. The purpose of bridging education is to address perceived gaps between the prior knowledge and experience immigrants possess and the standards required to practice in Canada (Lum, 2009). When nursing regulatory bodies identify a gap in the competency level of an IEN, successful completion of a bridging program may be required to fulfill the conditions of licensure (CASN, 2012). In Canada, the responsibility for credential and competency assessment lies with the regulator, while nursing bridging programs usually fall under the jurisdiction of an educational institution (CASN, 2012).

CASN (2012) published a Pan-Canadian Framework of Guiding Principles and Essential Components for IEN bridging programs. The framework was developed in consultation with nursing educators, regulators, and employers across Canada. The CASN Framework defined nursing bridging programs as "any program designed to address gaps and/or differences in education and competencies so that the internationally educated nurse may become registered to practice in Canada, and facilitates successful integration into the Canada healthcare system" (CASN, 2012, p. 2).

In the activities leading up to the development of the Framework, an environmental scan was conducted. The environmental scan identified 35 bridging programs for IENs in Canada. Of the 35 programs, 19 were RN bridging programs, 10 were LPN bridging programs, and 6 offered a combined RN and LPN bridging program. Bridging programs varied significantly in structure and design; Programs were offered both full-time and part-time, and differed in curricula content, length, methods of teaching, clinical placement experiences, and the availability of language instruction (CASN, 2012). In an effort to address the inconsistencies in programs and program effectiveness, the CASN Framework outlined best practices for nursing bridging education and identified guiding principles for effective programs. The report stated:

Bridging programs:

- Assist IENs to meet registration requirements as determined by the Registered Nurse or Licensed Practical Nurse regulator body and facilitate successful integration into the Canadian healthcare system.
- Recognize the uniqueness of the IEN learner while building on their capacity for leaning to prepare them for subsequent employment in the Canadian health care system.
- Establish collaborative partnerships with relevant stakeholder groups.
- Provide a safe learning environment, in which culturally competent faculty use teaching approaches that are appropriate for a diverse, multicultural group of learners.
- Are appropriately resourced.
- Have easily accessible and transparent program information.
- Have an evaluation framework, results of which are used to inform program changes. (CASN, 2012, p. 16)

Research examining the effectiveness of IEN bridging education is limited. A recent descriptive review of the literature associated with oral communication and IEN integration cited the important role IEN bridging education can play in developing both academic language ability and the cultural language skills required to work effectively within the healthcare environment (Lum et al., 2015. An earlier study by Bourgeault et al. (2010) reported that bridging programs were often identified as a "facilitator for integration" (p. 86) amongst IEHPs. Assistance with preparation for national examinations as well as providing orientation to culturally appropriate communication and patient interaction were amongst the benefits cited. However, participants also identified a number of challenges with professional bridging programs. The accessibility of bridging programs, limited available spaces, the financial burden of taking a course of study, and the content not adequately tailored to address the need of the IEHP were all identified as issues (Bourgeault et al., 2010).

Attitudes. The attitudes of host country nursing staff toward IENs are emerging as an important factor impacting the integration of IENs into the nursing workforce. Gerrish and Griffith (2004) commented on the importance of ward atmosphere, noting that "from the overseas nurses' perspectives, integration into the nursing team was facilitated if senior ward nurses were approachable and supportive" (p. 583). Similarly, IENs in Jose's (2011) study regarded support from co-workers as vital for adaptation and survival in the workplace. In many cases, this support was not available. Kawi and Xu (2009) concluded that many IENs felt there was inadequate support from colleagues and supervisors throughout the adjustment process, and unsupportive attitudes and behaviours from peers were not uncommon. IENs often felt misunderstood and at times mistreated, which cultivated feelings of resentment, inferiority, and humiliation.

Discrimination on the basis of race or ethnicity. One of the primary concerns of Bourdieu's work centres on social inequality and how it is perpetuated and maintained through the use of capital (Mendoza et al., 2012). A shared habitus fosters a common perspective or shared world view that at times serves as a mechanism for marginalizing others who have different amounts and types of capital available to them (Mendoza et al., 2012). Those in a position to exercise power maintain the dominant habitus by promoting certain dispositions and actions over others (Shim, 2012). Racism and discrimination have been found to be one of the key barriers to successful integration of immigrants into both the host country and the Canadian workforce (Frideres, 2008; Grant, 2005; Kelly et al., 2012).

Discrimination and racism against migrant nurses have been reported in a number of studies and have been experienced in many forms (DiCicco-Bloom, 2004; Jones, Bifulco, & Gabe, 2009; Kawi & Xu, 2009; Kingma, 2008b; Likupe, 2015; Moyce et al., 2016; Wheeler et al., 2014; Winkelmann-Gleed & Seeley, 2005). The undermining of professional skills or bullying by colleagues, being given undesirable work assignments or lower wages, or being denied access to professional development opportunities have all been attributed to racism (Hawthorne, 2001; Kingma, 2008a; Winkelmann-Gleed & Seely, 2005). Discriminatory practices have been noted in several different countries. Internationally recruited nurses in the U.K. reported feeling excluded, having their competency questioned by both colleagues and patients, and experiencing hostility from other British nurses (Allan & Larsen, 2003; Gerrish & Griffith, 2004; Likupe, 2015). As well, managers interviewed for a report commissioned by the Royal College of Nursing (2003) described witnessing episodes of overt racism against internationally recruited nurses when they were first employed. Similarly, immigrant nurses in New South Wales, Australia described feelings of being marginalized on the basis of identity, ethnicity, and experience (Omeri & Atkins, 2002).

In Canada, three studies have highlighted the presence of discrimination and racism toward IENs. Tregunno et al. (2009) conducted semi-structured interviews with 30 newly registered IENs as they entered the workforce in Ontario. IENs shared their experiences of being 'treated as the other' or 'outsider' by patients, families, and colleagues. Lack of trust by colleagues as well as aggressive and racist remarks by patients were experienced by study participants. Gupta (2009) surveyed 593 nurses of colour registered in Ontario, and while the majority of nurses interviewed had not experienced racism at work, a significant proportion had. For instance, when asked if race, ethnicity, or colour had an effect on different aspects of their work life, 15.8% reported that these variables had an effect on their hiring, 18% believed they had an effect on their access to promotions, and 27% reported that they had

affected their relations with colleagues. Gupta (2009) found that racism existed in multiple forms including being infantilized, marginalized, degraded, or "put down".

Finally, IENs in a recent study by Higginbottom (2011) felt that the assignment of tasks unrelated to nursing, such as dishwashing and vacuuming, was reflective of discriminatory practices by employers or supervisors. IENs also questioned the fairness of credentialing decisions by the regulator, expressing concerns that decisions were based on existing stereotypes regarding the IEN's country of origin.

Racism and discrimination have been identified as a key barrier preventing the integration of IENs into the nursing workforce. Racist and discriminatory practices impact the nurse's ability to obtain employment and promotion (Gupta, 2009; Moyce et al., 2016; Winkelmann-Gleed & Seely, 2005), increase the nurse's sense of social isolation at work (Kingma, 2008a), and contribute to attrition from the workforce (Gupta, 2009; Wheeler et al., 2014).

The results of a comprehensive literature review identified a number of factors that impact the integration of IENs into the nursing workforce. Both the characteristics of the immigrant (the cultural, financial, and social capital) as well as the characteristics of the host society (policies, programs, and attitudes) have been found to influence workforce integration.

Defining workforce integration. Although the term workforce "integration" was widely referred to throughout research and policy papers on international nurse migration, theoretical definitions varied. Covell et al. (2016) defined workplace integration as the process of becoming a member of a profession where IEHPs were able to utilize their professional knowledge and skills. Raghuram (2007) emphasized the two-way process of integration, whereby the migrant and host society share responsibilities. The 'double-edgedness' of integration differentiates the concept from assimilation that "requires migrants to merge in with the 'indigenous' culture" (Raghuram, 2007, p. 2248). According to Raghuram (2007) the establishment of mechanisms to recognize and accredit foreign credentials was one of the key components of economic integration. Raijman and Ophir (2014) identified that the most common measures of economic integration amongst researchers were labour-force participation, occupational attainment, and earnings. The researchers noted, however, that social and cultural knowledge was an important component of workplace integration. This view was shared by a number of researchers who argued that the successful integration of IENs extended beyond entry into the profession and labour-force participation and required the acquisition of the necessary language skills, knowledge, and understanding of the scope of practice and relational skills required to practice in the profession (Allan & Westwood, 2016;

Duff et al., 2002; Lum et al., 2015; Tregunno et al., 2009). Incorporating elements from each of these researchers the following definition was developed.

Integration is a two-way process, whereby both the IEN and host society have shared responsibilities. Nursing workforce integration includes:

- The recognition of foreign credentials and the ability to obtain licensure and work as a nurse in Canada.
- The acquisition of the necessary sociocultural skills to work within the nursing profession
- Employment within the nursing workforce
- The match between pre-migration education and current employment.

Current gaps in the literature.

The review of the literature demonstrates that over the past fifteen years considerable research has been conducted on the concept of nurse migration. However, a number of gaps in the literature currently exist. First, many of the studies conducted to date have utilized qualitative designs and included a small number of participants. Although the findings from qualitative studies provide valuable insights on a number of salient issues, the small sample size limits the ability to generalize the findings to other groups of IENs. Research using a mixed-methods design could provide additional insights into the complex phenomenon of nurse migration.

Secondly, the preponderance of research studies have included IENs from multiple source countries, yet the issues faced by IENs from different countries may be diverse and complex (Buchan, Jobanputra, Gough, & Hutt, 2006). The experiences of IENs may differ significantly depending on the country of origin, historical and political context, educational background, and work experience. Thus research examining IEN integration from a single source country is needed. To date, very little primary research has been conducted in Canada on Philippine nurse migration and no research studies have been conducted examining Philippine nurse migration to the three Prairie Provinces.

Thirdly, the reasons RNs from the Philippines choose to work as LPNs upon migration to the Prairie Provinces have not previously been explored in the research literature. From 2006 to 2015, the annual growth of IENs practising as LPNs was 16.9%, yet little is known about this developing trend. The paucity of research examining RNs from the Philippines who work as URHWs is also a significant gap. The successful integration of IENs has the potential to

add to the overall supply of nurses; however, to realize this potential, the challenges Philippine IENs encounter while integrating into the Canadian workforce need to be better understood. Finally, little research has been conducted examining the supports and programs utilized by IENs in the Prairie Provinces. Effective policies to assist the integration of nurses from the Philippines into the Canadian workforce are essential, and research is needed to inform policy development.

Chapter Three: Methodology

This study, guided by the philosophical perspective of Critical Realism, utilized a mixed methods design to achieve the purpose and objectives of the research. An online questionnaire, comprised primarily of fixed response questions was completed by a sample of 172 IENs (88 LPNs and 84 RNs) who had migrated from the Philippines to Canada between 2008 and 2013. Follow-up qualitative interviews were conducted with a sub-sample of 22 survey participants. In addition, 10 semi-structured interviews were conducted with IENs from the Philippines who were currently working as URHWs in one of the three Prairie Provinces.

The following chapter will discuss the research methodology and will highlight each of decisions made while designing and conducting the study. The chapter has been divided into seven main sections: philosophical perspective, mixed-methods design, sampling design, data collection, data quality, ethical considerations, and data analysis.

Section One: Philosophical Perspective

Researchers utilize different and sometimes diametric approaches to conducting research that are often influenced by the philosophical position from which the researcher operates (Pearce, 2015). Beliefs regarding epistemology, ontology, and axiology guide the research design and the research methods employed. Firstly, epistemology is concerned with what knowledge is, how we gain knowledge of what we know, as well as the relationship between the researcher and what is being researched (Creswell & Plano Clark, 2007; Pearce, 2015). Epistemological beliefs run on a continuum from objectivism to subjectivism. Positivism assumes an objective perspective where researchers are impartial, and the knower and the known are independent (Creswell & Plano Clark, 2007; Lincoln & Guba, 1985; Pearce, 2015). Whereas, constructivism supposes a subjective perspective where all knowledge is relative and the knower and the known are inseparable (Creswell & Plano Clark, 2007; Lincoln & Guba, 1985). Secondly, ontology encompasses beliefs about the nature of reality (Teddlie & Tashakkori, 2010). The positivist paradigm holds that there is a single reality, while the constructivist paradigm maintains that there are multiple, socially constructed realities (Creswell & Plano Clark, 2007; Lincoln & Guba, 1985). Finally, the axiological continuum represents the degree to which values are or are not a part of social inquiry and which ones are used (Teddlie & Tashakkori, 2009). The positivist paradigm espouses an unbiased approach where researchers attempt to eliminate bias, while the constructivist paradigm believes that

inquiry is value bound, and bias is inherent in research (Creswell & Plano Clark, 2007; Lincoln & Guba, 1985).

Methodology. Methodology is concerned with the process and the procedures by which knowledge is created (Wynn & Williams, 2012). These two distinct paradigms espouse different and often opposing methodological perspectives. Quantitative methodology, assumed to be value neutral, deductive, and generalizable is consistent with the positivist paradigm, while qualitative methodology that is interpretive, inductive, and context-specific is consistent with constructivism (Pearce, 2015). A number of scholars regard these two divergent approaches to conducting research as antithetical. The scientists operate within different paradigms and therefore the researcher is advised to choose either a qualitative or quantitative approach (Kuhn, 1970; Lincoln & Guba, 1985). These opposing world views have often resulted in quantitative researchers relegating qualitative methods to a secondary role in research, and qualitative researchers rejecting the central tenets of quantitative design and analysis (Maxwell & Mittapalli, 2010).

This dualistic view of qualitative and quantitative approaches has been challenged by a number of scholars who argue for a more pragmatic approach, where the choice of qualitative, quantitative, or mixed methods should be directed by the research question rather than the particular philosophical position (Greene & Hall, 2010; Tashakkori & Teddlie, 1998/2008). According to Biesta (2010), the "incompatibility thesis" of different paradigms is both unhelpful and imprecise: "The simple problem here is that research *in itself* can be neither qualitative nor quantitative; only *data* can properly be said to be qualitative or quantitative" (p. 98). Paradigm thinking that combines discussions on methodology, epistemology, and ontology with the nature of the data being collected tends to obscure the potential strengths and complementarity of both qualitative and quantitative approaches (Biesta, 2010). Thus for methodological pragmatists, methods can be combined on the basis of their practicality without concern for paradigmatic conflict (Maxwell & Mittapalli, 2010). However, as Maxwell and Mittapalli (2010) contend:

> Urging researchers to simply set aside these paradigmatic assumptions is not just unrealistic, but counterproductive. Paradigmatic assumptions function not simply as constraints on methods but as lenses for viewing the world, revealing phenomena and generating insights that would be difficult to obtain with other lenses. (p.147)

Critical realism. Critical realism is a distinctive philosophy of science that is emerging as an alternative to positivism and constructivism (Wynn & Williams, 2012). Initially

formulated by Bhaskar (1975) and subsequently extended by others (eg. Archer, 1995; Collier, 1994; Sayer, 1992), critical realism leverages elements of both paradigms, combining an ontological realism with an epistemological relativism (Frauley & Pearce, 2007; Wynn & Williams, 2012). A central tenet of critical realism is that reality exists independent of our knowledge of it and independent of our ability to perceive it (Frauley & Pearce, 2007). While critical realism rejects the idea of 'multiple realities,' it acknowledges that there are different valid perspectives on the world and these perspectives are a component of the world we aim to understand (Maxwell & Mittapalli, 2010; Phillips, 1987). Thus critical realism recognizes that the nature of reality is not easily categorized or measured and is not simply reducible to our perceptions or experiences. It is only possible for humans to experience a fragment of reality and our knowledge of that reality is fallible (Wynn & Williams, 2012).

Critical realism espouses that reality is stratified into three domains: the *real*, the *actual*, and the *empirical*. As Wynn and Williams (2012) explain:

> The domain of the *real* includes the entities and structures of reality and the causal powers inherent to them as they independently exist. The next domain, the *actual*, is a subset of the real that includes the events that occur when the causal powers of structures or entities are enacted, regardless of whether or not these are observed by humans. The final domain, the *empirical*, is a subset of the actual and consists of those events which we are able to experience via perception or measurement. (p. 790)

Thus, critical realism holds that there is a deeper reality (the *real)* underpinning what we can see or what we can know (the *empirical)* (Frauley & Pearce, 2007). Critical realism views reality as an open system that is beyond our ability to control directly (Frauley & Pearce, 2007). In contrast to a closed system, where control and manipulation are possible, an open system has many interacting structures and mechanisms (Harwood & Clark, 2012). The assumptions of this view of reality form the basis upon which epistemology and subsequent methodological practices are founded.

In critical realism, a distinction is made between intransitive and transitive dimensions of scientific knowledge. The intransitive dimension includes the entities or objects of the real world that we try to explain but are largely independent of our senses and experiences. Researchers try to understand this dimension through socially constructed theories that comprise the transitive dimension (Bergen, Wells, & Owen, 2010; Harwood & Clark, 2012). It is this knowledge that informs our understanding of what exists (epistemology). Critical realism assumes that knowledge is necessarily fallible, alterable, and although the intransitive elements in the natural world do not change, the transitive dimension, our theories, will change (Wynn & Williams, 2012).

Critical realism supposes that social phenomena are best researched in a 'real world' open setting rather than an 'experimental' closed setting that cannot sufficiently mirror the complexity of reality. Through a critical realist lens an explanation of the mechanisms that generate certain events is sought, rather than the ability to make precise predictions. In an open system regularly occurring events are the exception; outcomes of mechanisms are rarely identical across contexts, making it difficult to formulate predictions (Bhaskar, 1975; Frauley & Pearce, 2007; Wynn & Williams, 2012).

Critical realism is explicitly concerned with ontology. While positivistic and constructivist research designs "emphasize *how* knowledge is to be generated," critical realist designs focus on "*what* the object of the investigation must be like in order for it to be known in the way proposed" (Frauley & Pearce, 2007, p. 17). It begins with questions about what exists, the conditions under which social objects emerge, and moves to questions of epistemology, concerned with the production of knowledge about the phenomenon (Frauley & Pearce, 2007). In contrast to the belief that research methods rooted in the positivist paradigm (quantitative) are incompatible with those embedded in the constructivist paradigm (qualitative), critical realism treats both methods as equally valid and useful (Maxwell & Mitapalli, 2010). As a philosophical perspective that values each approach, critical realist designs can be qualitative, quantitative, or mixed methods (Maxwell & Mittapalli, 2010; Wynn & Williams, 2012).

The central tenets of critical realism: the acknowledgement of different and valid perspectives, the view of reality as an open versus closed system, the aim to understand rather than control phenomenon, and the value of different methods to generate knowledge, were consistent with the philosophical perspective of the researcher. Through a critical realist lens the complex nature of workforce integration of IENs as well as the factors (mechanisms) that facilitate or challenge their integration could be fully explored.

Section Two: Mixed Methods Designs

The following section will define mixed methods and describe the research design utilized in this study. A number of design considerations will be discussed including the purpose of integration, the timing of qualitative and quantitative data collection, the weighting of the qualitative and quantitative components, and the phase of data merging.

Defining mixed methods. A number of definitions of mixed methods have been advanced over the years (Johnson, Onwuegbuzie, & Turner, 2007). While some scholars have

emphasized a philosophical or methodological orientation, others have adopted a methods perspective (Creswell, 2015). As critical realism provides the philosophical underpinnings of this research, definitions focusing on the mixing of paradigms were not considered consistent; instead Creswell's (2015) definition that adopts a methods orientation was considered most relevant. According to Creswell (2015), "Mixed methods is an approach to research in which the investigator collects, analyzes, and interprets both quantitative and qualitative data (closed- and open-ended information), integrates or combines the two approaches in various ways, and frames the study within a specific type of design or procedure" (p. 59). This definition clearly views mixed methods as a "method" and highlights that it is not simply the collecting and analyzing of both qualitative and quantitative data in a single study but rather includes, as a central component, the integration of the two types of data at some point in the study, thus enhancing both the qualitative and quantitative strand (Creswell, 2015).

Furthermore, Creswell (2015) contends that mixed methods is not simply adding qualitative data to a quantitative study or vice versa, where the "added" component has diminished stature, but rather utilizing both qualitative and quantitative approaches in a manner that affords each approach equal value. Finally, Creswell (2015) argues that mixed methods is not collecting qualitative data and analyzing it quantitatively as "the full advantage of mixed methods follows from collecting *both* quantitative and qualitative data" (p. 60).

Design considerations in mixed methods research. In recent years a number of distinct mixed methods designs have been discussed in the literature (Creswell, Plano Clark, Gutmann, & Hanson, 2003/2008; Creswell, 2015; Morse, 2015; Teddlie & Tashakkori, 2010). While each design varies in name and level of complexity, the underlying dimensions upon which each design is constructed are based on four key considerations: the purpose of integration of qualitative and quantitative approaches, the timing of the qualitative and quantitative data collected, the weighting or dominance of the qualitative and quantitative components, and the phase of the research process where data are merged (Bryman, 2006/2008; Creswell et al., 2003/2008; Creswell & Plano Clark, 2007).

The purpose of integration. Before designing a mixed methods study, it is important to consider the reasons for integrating qualitative and quantitative approaches. Greene, Caracelli, and Graham (1989/2008) reviewed 57 mixed methods studies and categorized the reasons researchers provided for conducting mixed methods research into five main purposes. The categories included triangulation, complementarity, development, initiation, and expansion and were described as follows:

- *Triangulation* seeks convergence, corroboration, correspondence of results from different methods.
- *Complementarity* seeks elaboration, enhancement, illustration, clarification or the results from one method with the results from the other method.
- *Development* seeks to use the results from one method to help develop or inform the other method, where development is broadly construed to include sampling and implementation, as well as measurement decisions.
- *Initiation* seeks the discovery of paradox and contradiction, new perspectives of frameworks, the recasting of questions or results from one method with questions or results from the other method.
- *Expansion* seeks to extend the breadth and range of inquiry by using different methods for different inquiry components. (Greene et al., 1989/2008, p. 127)

Based on this typology, the primary purpose of mixing qualitative and quantitative approaches in this research study was determined to be *complementarity*. Qualitative and quantitative approaches were used to explore different but overlapping facets of the phenomenon, with the intent of yielding an enhanced understanding of the phenomenon (Greene et al., 1989/2008). In essence, 'to put meat on the bones' of 'dry' quantitative findings (Bryman, 2006/2008, p. 263). Complementarity was accomplished in two ways. First, while the majority of questions on the online survey were closed-ended, a number of open-ended questions were included to allow further elaboration of answers. For example, the question *"Do you think your current nursing position is appropriate given your knowledge and experience. Yes or No?* Was followed with the open ended statement, "*Please explain,"* allowing for further elaboration and illustration of *why* the participant answered in the manner they did.

Second, qualitative interviews were conducted with a subsample of participants who completed the online survey. The qualitative interviews provided an opportunity to explore, in greater depth, the challenges and supports associated with the phenomenon of workforce integration. For example, during the online survey, participants were asked to rank, quantitatively, the perceived difficulty of challenges (language, communication, delegation, etc.) encountered throughout their integration into the nursing workforce. Additionally, during the qualitative interviews, a small sub-set of participants were asked to elaborate, to discuss in depth, any challenges they had encountered, thus substantially enriching the study findings through stories and examples.

The second reason for adopting a mixed methods approach was *triangulation*. The use of two methods provided a means "to obtain different but complementary data on the same topic" (Morse, 1991, p. 122). The different methods allowed the researcher to confirm or corroborate findings from one data set with the other and provided a mechanism to validate and

substantiate study findings (Creswell et al., 2003/2008). To accomplish this, online survey responses were compared and validated with data obtained during the semi-structured interviews, and conversely, themes identified in the qualitative analysis were analyzed alongside the quantitative findings.

The final purpose of using a mixed methods approach in this research study was *expansion*, in essence to extend the breadth of the inquiry by selecting methods most appropriate for different inquiry components (Greene et al., 1989/2008). Thus, qualitative and quantitative approaches were employed to answer different research questions. For example, fixed response quantitative survey questions were best suited to address the research questions focusing on demographic characteristics as well as questions on the past and current workforce profile of IENs, while open ended qualitative questions were most appropriate to explore the factors associated with the decision to work as an URHW, LPN, or RN in Canada, as little was known about this phenomenon.

The timing of qualitative and quantitative data collection. When selecting a mixed methods design, it was also important to consider the timing of the qualitative and quantitative data collection. Data can be collected concurrently with both qualitative and quantitative data being gathered at the same time or collected sequentially with either the qualitative or quantitative data gathered first (Creswell et al., 2003/2008). Ultimately, the timing of data collection relates to the purpose of combining approaches. In sequential designs the data collected and analyzed from the first phase of the research are used to inform subsequent phases (Onwuegbuzie & Johnson, 2006/2008). This design is characterized by an initial stage of data collection and analysis (qualitative or quantitative) followed by second stage of data collection and analysis (quantitative or qualitative). The purpose of this design is largely to build on the results from the first phase during the second phase; for example, qualitative data from the initial phase may inform the development of an instrument that can then be used during the second (quantitative) phase (Creswell et al., 2003/2008). By contrast, concurrent designs are often selected when the purpose of employing two different methods is to corroborate or confirm findings within a single study and when the researcher seeks to expand quantitative results with qualitative data (Creswell et al., 2003/2008; Creswell & Plano Clark, 2007). According to Onwuegbuzie & Johnson (2006/2008) in concurrent mixed methods designs the following conditions hold:

(a) both the quantitative and qualitative data are collected separately at approximately the same point in time,
(b) neither the quantitative or qualitative data analysis builds on the other during the data analysis stage, and
(c) the results from each type of analysis are not consolidated at the interpretation stage until *both* sets of data have been collected and analyzed separately, and
(d) after collection and interpretation of data from the quantitative and qualitative components, a meta inference is drawn which integrates the inferences made from the separate quantitative and qualitative data and findings. (Onwuegbuzie & Johnson, 2006/2008, p. 281)

As the primary purposes for mixing methods in this study were *complementarity and triangulation*, a concurrent design was considered most appropriate (Creswell & Plano Clark, 2007; Onwuegbuzie & Combs, 2010). For strand one, data were collected from LPN and RN participants over a four month period of time. The online survey was comprised predominantly of closed-ended quantitative questions that allowed for the exploration of concepts with a larger sample of IENs. A small number of open-ended qualitative questions were also included in the survey to complement and enrich the findings. In addition, semi-structured interviews were conducted with a subsample of survey participants, which allowed for more in-depth exploration of phenomena as well as the corroboration of survey responses. In strand two of the study, semi-structured interviews were conducted with URHW participants over a seven month period of time. The semi-structured interviews were comprised of both open ended (primarily) and fixed response questions. Once the data collection for both strands of the study were complete, the qualitative and quantitative data analyses were carried out separately. After the analyses of both data sets were concluded, the findings were consolidated and interpreted together.

The weighting of qualitative and quantitative components. In the design of a mixed methods study the researcher also needs to consider the weighting or emphasis placed on the qualitative and quantitative components (Creswell & Plano Clark, 2007). According to Creswell and Plano Clark (2007), "weighting refers to the relative importance or priority of the quantitative and qualitative methods in answering the study's questions" (p. 81). In a mixed methods study, either the qualitative and quantitative components are weighted equally with both methods having equal emphasis or unequally with either method being assigned a greater priority (Creswell & Plano Clark, 2007). The decision regarding the relative weight of each component is determined by the purpose of the research and the strength of each method in addressing the research questions (Creswell & Plano Clark, 2007).

The purpose of this research study was exploratory and descriptive. Both qualitative and quantitative approaches were utilized as one method could expand, complement, and corroborate the data obtained from the other. Both methods were of equal importance in answering the research questions and thus both qualitative and quantitative components were weighted equally. In reaching this decision, a number of mixed methods research designs were reviewed and the weighting of the qualitative and quantitative components were considered (Creswell et al., 2003/2008; Creswell & Plano Clark, 2007; Luzzo, 1995/2008; Morse, 2010); the equal weighting of both methods was determined to be most appropriate.

The phase of data merging. There is growing consensus amongst scholars on mixed methods research that simply using qualitative and quantitative approaches in a single study is not sufficient, but rather the integration of qualitative and quantitative findings is required (Maxwell, Chmiel, & Rogers, 2015). As Bryman (2007) notes,

> Mixed methods is not necessarily just an exercise in testing findings against each other. Instead, it is about forging an overall or negotiated account of the findings that brings together both components... In genuinely integrated studies, the quantitative and the qualitative findings will be mutually informative. They will talk to each other, much like a conversation or debate, and the idea is to construct a negotiated account of what they mean together. (pp. 20-21)

Morse (2015) describes the position in the research design where the different types of data are brought together as "*the point of interface"* (p. 214). This *point of interface* between quantitative and qualitative data can occur at a number of different times throughout a mixed methods study. For example, one methodological strand may interconnect and inform the other before the interpretation stage. During the data analysis the qualitative and quantitative data may be consolidated or transformed and the two data sets analyzed as one, or the data analysis for each strand may occur in parallel, and once both analyses are complete, the findings are linked or integrated into meta-inferences (Onwuegbuzie & Combs, 2010; Teddlie & Tashakkori, 2009).

The parallel mixed analysis is one of the most common approaches utilized by mixed methods researchers (Teddlie & Tashakkori, 2009) and is considered appropriate for designs that seek *complementarity* and *triangulation* through the use of mixed approaches (Creswell & Plano Clark, 2007; Onwuegbuzie & Combs, 2010). Therefore, in this study, a parallel approach to data analysis was undertaken; qualitative and quantitative data were analyzed independently and brought together once the analysis of each component was complete. At this time, quantitative findings were reviewed and interpreted alongside the corresponding

qualitative findings and the results were integrated in the writing of the results narrative (Dahlberg, Wittink, & Gallo, 2010; Morse, 2015).

The research design. To summarize, this research used a concurrent, mixed methods design where qualitative and quantitative data were collected at relatively the same point in time and were equally weighted. A parallel approach to data analysis was undertaken and quantitative and qualitative analyses were conducted independently. Data merging occurred once the final analyses were complete (see Figure 4).

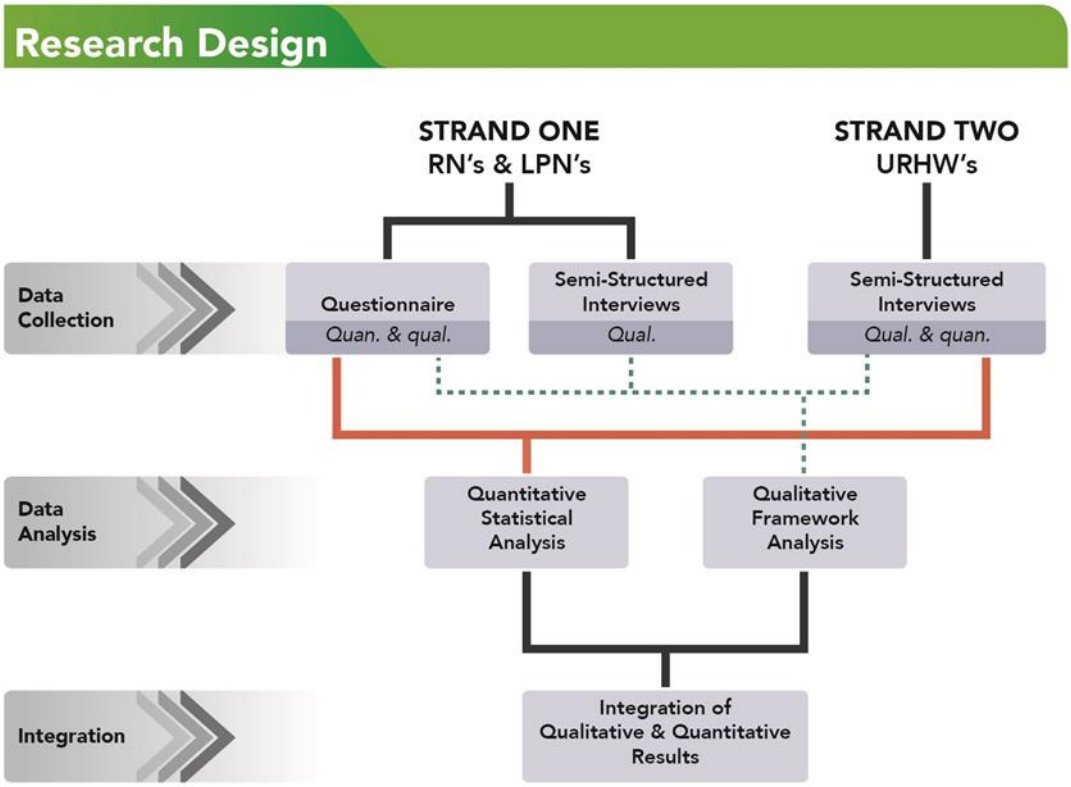

Figure 4. Research design of primary study.
Source: Author

Section Three: Sampling Design

Identifying the target population. The target population for this research study was identified as internationally educated registered nurses from the Philippines who were recent migrants to Canada and were integrating into the nursing workforce in one of the three Prairie

Provinces. The rationale for choosing this target population was twofold. First, in the literature IENs have often been regarded as one group, similar to each other, but different from nurses in the host country. However, this view is at best an oversimplification (Buchan et al., 2006), as the experiences of IENs may differ substantially depending on the country of origin. For this reason, the researcher felt it was important to limit the focus to IENs from one country, the Philippines. By focusing on a single source country it was possible to gain a better understanding of the supports and challenges encountered by this individual group of IENs. This knowledge will contribute to the growing body of research on IENs and will help inform policy, programs, and supports designed to assist Philippine IENs transition into the nursing workforce in Canada. The decision to study IENs from the Philippines was made as this group comprised the largest number of IENs migrating to Canada as well as the largest group of IENs entering and integrating into the Western Canadian health workforce (CIHI, 2016d, Gupta 2016).

Second, when the study was first conceptualized the initial target population included IENs in the geographic region of Western Canada (comprised of the four Canadian provinces Manitoba, Saskatchewan, Alberta, and British Columbia). However, early in the research process it became apparent that accessing the RN and LPN population of IENs in British Columbia would not be feasible. In light of this, the decision to redefine the population to target IENs from the three Prairie Provinces was made. The geographic region of the Canadian Prairie Provinces (Manitoba, Saskatchewan, and Alberta) was chosen for a number of reasons. Firstly, each of the Prairie Provinces had a signed bilateral trade agreement with the Philippines that was designed to encourage the migration of skilled workers from the Philippines to Canada. Secondly, the registration process and policies for IEN assessment were similar across the three provinces. And thirdly, limited research on Philippine nurse migration had been conducted in this region of Canada.

Inclusion criteria. Once the target population had been identified, the next step in the research process was to establish the eligibility criteria for inclusion in the study. To best reflect the target population, it was determined that eligible participants had to be IENs initially educated and registered as RNs in the Philippines. Previous registration as a RN was required as this was essential for eligibility to apply for licensure as a RN in Canada. In addition, as the primary objective of this research was to explore and describe the integration of Philippine IENs into the current nursing workforce, it was considered important to focus on IENs who had recently arrived in Canada and had experienced integration into the nursing workforce as

a RN, LPN, or URHW. For the purpose of this research, "recent" was defined as within the previous five years.

The inclusion criteria were as follows:

1. Internationally educated nurses who completed their entry level nursing education in the Philippines.
2. Internationally educated nurses who were previously registered as a Registered Nurse in the Philippines.
3. Internationally educated nurses from the Philippines who arrived in Canada after January 1st, 2008.
4. Internationally educated nurses from the Philippines who were currently a RN, LPN or URHW in Manitoba, Saskatchewan or Alberta.

Selection of participants. The process of selecting a sample from the population of interest was the next step in the sampling design (Collins, 2010). In this mixed methods study the sampling design involved two distinct strands. The first strand included the sample selection process for the RN and LPN participants and the second strand included the sample selection process for URHW participants.

Strand one: Selection of RN and LPN participants. The study design included the distribution of an online questionnaire and follow up interviews with RN and LPN participants. First, it was necessary to decide on a mechanism to obtain a sample for the online survey, and second it was important to determine the process that would be used to gather the participants for the interviews.

Survey participants. In Canada, all active practicing nurses are required to register with the licensing body in the province in which they work. Thus, all IENs from the Philippines who are working as LPNs or RNs are included on the register of the associated licensing body. For this reason it was determined that the regulators could provide the best access to the target population; therefore, a request for research access was submitted to each of the six regulators in the three Prairie Provinces. The regulatory bodies included the College and Association of Registered Nurses of Alberta (CARNA), the College of Licensed Practical Nurses of Alberta (CLPNA), the Saskatchewan Association of Licensed Practical Nurses (SALPN), the Saskatchewan Association of Registered Nurses (SRNA), the College of Registered Nurses of Manitoba (CRNM), and the College of Licensed Practical Nurses of Manitoba (CLPNM). Five

of the six regulators (CARNA, CLPNA, SALPN, CRNM, and CLPNM) granted access; however, one of the regulators (SRNA) denied research access. As a result, the RN Philippine IEN population in Saskatchewan were accessed through the Philippine nursing network.

Accessing potential participants through six separate organizations, all with slightly different protocols, made it unworkable to employ a probability sampling technique. Probability sampling would have required the development of a sampling frame that included all members of the target population (Dillman, Smyth, & Christian, 2014; Polit & Beck, 2016). However, it was not feasible to establish a complete sampling frame from which the sample could be drawn. Each of the organizations had different database capabilities. While some of the regulators, CARNA for example, had the database capabilities to identify the subgroup of IENs from the Philippines, other regulatory bodies could only identify IENs as a single category. Manual data mining would have been required to isolate the subgroup of Philippine IENs and the fee required to accomplish this was cost prohibitive to the researcher.

Furthermore, the protocol for contacting participants differed between organizations. The Philippine nursing network in Saskatchewan distributed an invitation to all IENs on their contact list. Similarly, the CLPNA, SALPN, CRNM, and CLPNM distributed an email invitation to potential participants. The survey link was embedded in the email and interested IENs were redirected to the online survey. As some of the email invitations were distributed to IENs that may not meet the eligibility criteria, the criteria were included in the initial email. In addition, four screening questions were included at the start of the survey. If a potential participant opened the survey link but did not meet the study criteria, they were automatically directed to the end of the survey where they were thanked for their interest in the research. The protocol with CARNA differed slightly. CARNA generated a list of email addresses for all IENs who met the eligibility criteria, and the recruitment email and survey link was sent directly to potential participants from the survey administrator.

Although commonly used in nursing and social science research, nonprobability approaches to sampling are less likely than probability samples to generate a representative sample (Polit & Beck, 2012). In cases where nonprobability sampling is required, the researcher can undertake a number of steps to strengthen the design and enhance the likelihood of a achieving a more representative sample. First, the risk of bias is reduced in populations that are relatively homogenous (Polit & Beck, 2016). By targeting IENs from a single country of origin, limiting participants to IENs who had migrated in the previous five years, and including only those IENs who had migrated to one of the three Canadian Prairie Provinces, the heterogeneity of the sample was decreased, and as a result, the potential for bias was reduced.

Second, the use of consecutive sampling, which involved "recruiting ***all*** [italics in original] of the people from an accessible population who meet the eligibility criteria over a specific time interval" (Polit & Beck, 2016, p. 723) was utilized. Consecutive sampling is a stronger approach than simply sampling by convenience (Polit & Beck, 2016). It can be undertaken over a retrospective or prospective time period, and when the time frame is sufficiently long, the risk of potential bias from time related variability can be reduced (Polit & Beck, 2016). For this reason, *all* eligible IENs were invited to participate. The time period for inclusion was based on year of migration and was established between 2008 and 2013. This time period was considered sufficiently long to reduce bias from time associated fluctuations as well as produce an adequate number of participants.

When designing the sampling approach for survey research, it was also important to address the potential for coverage error (Dillman et al., 2014). According to Dillman et al. (2014), coverage error occurs when the sampling frame does not accurately represent the population of interest. Coverage error can be minimized with the use of probability sampling (Dillman et al., 2014); however, as a nonprobability sample was required in this study, a number of steps were undertaken to ensure coverage error was minimized.

First, as all RNs and LPNs were required to be licensed with the applicable regulatory body, accessing IENs through the nursing regulators provided the best access to the target population. Through the regulators it was possible to send email invitations to all eligible IENs who had previously provided consent to be contacted for research purposes. Second, computer access and the level of computer literacy of the sample participants were important considerations. If a large number of eligible participants did not have access to a computer or did not have the required computer literacy to complete an online survey then a coverage bias would result (Sue & Ritter, 2007). Currently nurses in Canada complete their registration renewal online. In addition, notifications and newsletters from the regulatory bodies were frequently distributed through email. As the majority of nurses required access to a computer and email to fulfill the requirements of their registration, it was felt the coverage bias would be minimal.

Coverage bias was further reduced by the use of an additional survey mode (Dillman et al., 2014). In the email invitation sent to potential participants an option was provided to contact the researcher via email to request a mailed copy of the questionnaire. The second mode was offered in an attempt to reach participants who were interested in participating but who were reluctant to complete the survey online (Dillman et al., 2014).

*Interview participants***.** Once the sampling design for the online survey had been determined, the next decision involved the selection of participants for the qualitative interviews. Onwuegbuzie and Collins (2007) contend that one of the pivotal factors to consider in choosing the sampling design for mixed methods research is the relationship between the two data components: identical, parallel, nested, or multilevel. Collins (2010) defines each of these relationships as follows:

- Identical relationships occur when the same sample participates in both components of the study.
- Parallel relationships indicate that the samples in each component of the study are different but selected from the same population.
- Nested relationships follow when the sample participating in one phase is a subset of the sample that participated in the other phase.
- Multilevel relationships occur when the two samples are selected from different populations entirely.

The purpose of conducting the mixed methods research guides the sampling design (Collins, 2010). The primary purposes for using a mixed methods design in this study were to achieve, *Complementarity*, *Expansion*, and *Triangulation.* To accomplish this it was considered appropriate to select the same sample participants to participate in both the online survey and qualitative interview components of the study (Collins, 2010). Involving all 172 participants, by using an identical sample for both the online survey and the qualitative interviews, was not feasible however. A nested sample, where a small subset of survey participants were selected to take part in follow up qualitative interviews, has been used with success in a number of published research studies (Kelly et.al, 2012; Sargeant et al. 2008; Talbert et al. 2016) and was therefore considered the most appropriate sampling strategy to utilize.

In order to obtain the subsample for the qualitative interviews the following statement was included at the end of the online survey: *As part of my ongoing research into the experiences of IENs from the Philippines, I may wish to contact you again to invite you to participate in a focus group interview. Would you be interested in being contacted in the future?* Participants were asked to provide a yes or no response. If they indicated that they were interested in further participation, they were asked to provide their name, telephone number, and email address. To ensure the anonymity of their survey responses this information was submitted separately from the survey.

To determine the appropriate sample size for the qualitative interviews the point of data saturation was considered. Data saturation is reached when no new information or insights are obtained from sampling additional participants and informational redundancy is achieved (Merriam & Tisdell, 2016). Data saturation is influenced by the complexity of the data collected as well as the homogeneity of the sample. The more complex the data and the greater the heterogeneity of the sample, the larger the number of participants required to reach saturation (Guest, Bunce, & Johnson, 2006). Guest et al. (2006) conducted 60 in-depth qualitative interviews in an attempt to determine how many interviews were required to reach data saturation. Inclusion criteria produce a relatively homogenous sample and the researchers concluded that data saturation occurred after 12 interviews.

In this study, RN and LPN participants were relatively homogenous, and the topics covered in the telephone interviews were minimally complex. As a result, data saturation was achieved after 20 interviews. At this point, the researcher noted that participants' responses were similar and no new information was forthcoming. Polit and Beck (2012) however, suggest that beginning researchers should "test" whether data saturation has been achieved by adding one or two cases after the point of saturation to ensure no new insights emerge. For this reason, an additional two interviews were undertaken. The additional interviews did not yield any new information; therefore, no further interviews were scheduled.

Strand two: Selection of URHW participants. Accessing registered nurses from the Philippines who were currently working as URHWs in Canada presented a significant challenge. In order to contact this difficult to locate population, a network or snowball approach to sampling was utilized (LoBiondo-Wood & Haber, 2013). Snowball sampling takes advantage of social networks and the tendency for individuals within a network to share characteristics. Once a few eligible individuals were located, the initial participants were asked to refer other similar individuals who may be interested in taking part in the research (LoBiondo-Wood & Haber, 2013). The initial participants were recruited through an advertisement sent to the local Philippine nursing communities in Alberta, Saskatchewan, and Manitoba. Interested participants were asked to contact the researcher via email or telephone. A face to face or telephone interview was then conducted with those IENs who met the eligibility criteria and agreed to participate in the study. Upon completion of the interview participants were asked to pass on the researcher's contact information to any other IENs they knew who met the study criteria and might be interested in participating.

While the goal was to obtain theoretical saturation of the data from URHW participants, the sample size for this group was also based on practical considerations. Recruitment of this

group of participants was extremely challenging, and after 7 months of data collection only 10 participants had been recruited. After 10 interviews many of the issues participants brought forward were similar, and when paired with the qualitative online survey data from 44 LPNs and 26 RNs who indicated that they had also worked as an URHW before becoming licensed as a nurse in Canada, the data was considered sufficient to adequately address the research questions; therefore, no further attempts to schedule additional interviews were made.

Section Four: Data Collection

Developing a plan for data collection is one of the key considerations in carrying out a research study. Deciding on the methods to be used for data collection as well as the data collection tools and procedures are important steps in the research design (Polit & Beck, 2016). The following section will outline the data collection process.

Methods of data collection. One of the first decisions the researcher had to make was the mode of data collection. For this study data were collected through questionnaires distributed online and semi-structured interviews.

Online survey. A survey is designed to collect self-reported information about participants' attitudes, beliefs, or experiences. One of the advantages of a survey is its flexibility and broad scope (Polit & Beck, 2016). Survey data can be collected through interviews or self-administered questionnaires (Polit & Beck, 2010). In the past, surveys were frequently administered via telephone, mail, or face to face interviews, but rapid technological advances and the increased availability of the internet over the past 15 years has resulted in the expanded use of online surveys as a mode of data collection. While face to face and telephone interviews have the advantage of higher response rates (Leedy & Ormrod, 2010), the expense and time required to conduct interviews with a large number of participants across the Canadian Prairie Provinces were seen to be prohibitive. Alternatively, online surveys have been found to provide a low cost and efficient data collection method (Dillman et al., 2014; Sue & Ritter, 2007) and have been shown to be an effective mode to gather data from participants across a large geographic region (Sue & Ritter, 2007).

The effectiveness, efficiency, and affordability of online surveys, combined with the computer and email access amongst IENs, made the use of online surveys an appropriate mode of data collection for this research study. However, at the time the research study was conducted, limited research using online surveys in the IEN population could be found, and

thus the acceptance of this mode of data collection was unknown to the researcher. To address this concern a second mode, a mailed questionnaire, was added to the research design. Adding the additional mode provided participants with an alternative method of completing the survey, a strategy that has been found to increase response rates and reduce nonresponse error by appealing to different respondents (Dillman et al., 2014). As the data quality has been found to be comparable in both mail and online surveys (Kwak & Radler, 2002), offering participants a choice would not compromise the quality of the data collected.

Qualitative descriptive interviews. Qualitative description is a method in its own right and differs from other qualitative methods in several significant ways (Sandelowski, 2000). Firstly, qualitative descriptive studies are less interpretive than other qualitative methodologies such as ethnography, phenomenology, and grounded theory. Qualitative descriptive studies generate findings closer to the data or "data near" (Sandelowski, 2010, p. 78), and interpretations of data are much less transformed than in other forms of qualitative research (Sandelowski, 2010). Secondly, in contrast to other qualitative approaches (ethnography, phenomenology, or grounded theory), qualitative descriptive studies are less bound by a particular philosophical perspective and findings are presented as detailed descriptions in everyday language. Researchers seek descriptive validity by obtaining a detailed account of a phenomena and the meaning participants attribute to it. This is not to suggest that qualitative descriptive studies lack rigour. As Sandelowski (2000) explains, "there is nothing trivial or easy about getting the facts, and meanings participants give to those facts, right and then conveying them in a coherent and useful manner" (p. 336). Finally, qualitative descriptive studies are especially useful to obtain clear and largely unadorned, "minimally theorized or otherwise transformed" (Sandelowski, 2000, p. 337), answers to questions of particular relevance to practitioners and policy makers. It is considered the qualitative method of choice when straight description of a phenomenon is desired (Sandelowski, 2000). Interviews are the predominant mode of data collection in qualitative descriptive research (Sandelowski, 2000).

Data collection procedures. Initially data were collected through an online questionnaire administered over a three week period of time (August to September 2013). An invitation was emailed to potential participants, in accordance with the policies of each of the Colleges and Associations, followed by two reminder notices sent one week apart (Sue & Ritter, 2007). A link for the online survey was embedded in the email invitation. Potential participants were also given the option of completing a mailed questionnaire. Those IENs interested in receiving a written questionnaire were asked to contact the researcher via email or telephone. Only one

request for a mailed questionnaire was received. The researcher mailed a copy of the questionnaire along with a postage paid addressed envelope to the participant. The completed questionnaire was not returned.

In follow up to the online survey, six focus group interviews (two in each of the Canadian Prairie Provinces) were initially planned with a small subsample of RN and LPN survey respondents. The focus group interviews were designed to further explore, validate, and expand on the responses provided in the questionnaires (Creswell, 2009). At the end of the questionnaire participants were asked to indicate if they were willing to have the researcher contact them to participate in future research. A total of 109 participants agreed to further follow up, and a random sample of LPNs and RNs in each province were initially emailed and invited to attend a focus group interview on a specified date. However, scheduling difficulties (work and childcare responsibilities) and not living close to the city where the focus group interview was planned (for example, a focus group was planned in Calgary but many of the participants from Alberta lived in Edmonton, 300 km away) were cited as key reasons participants could not attend.

A second set of invitations were sent to the remaining participants on the list, and of the 109 email invitations extended, only one LPN from Saskatchewan was able to attend a focus group interview. Although participants were unable to attend the scheduled focus group interviews, email responses indicated a high level of interest and willingness to participate in the research. For example, one participant emailed, "As much as [I] would like to share my experiences working as a nurse in Canada I can't I am currently living in Portage La Prairie and it is a long drive coming to Winnipeg. Anyway this is my cellphone number XXXXX/ Home number XXXXX you can give me a call any time, [I] am willing to extend all my help in order to assist you with your research." And another replied, "Thank you for the invitation! As much as [I] would like to attend to the said discussion and help you with your research, [I] regret to inform you that [I'm] not available on October 7. I'm working a 12-hour shift from 0700-1930."

Therefore, a decision was made to modify the research protocol to replace the focus group interviews with individual telephone interviews. As this was considered a significant deviation from protocol, a letter requesting the change, was submitted to the Queen Margaret University ethics board and permission for the modification was received. Once ethics approval was received, the participants who had previously agreed to participate in a focus group interview were contacted by email and asked if they were willing to participate in a telephone interview. A number agreed but additional recruitment was required. One week later an additional 30 emails were sent to a random sample of RNs and LPNs in each of the

three provinces. Within a two week time frame, a total of 10 RNs and 12 LPNs had agreed to participate in a telephone interview. A total of 22 telephone interviews were carried out in the late fall of 2013. Interviews were tape recorded to facilitate data transcription.

URHW participants. In 2013 a total of 10 semi-structured interviews were conducted with URHW participants over a seven month period of time. Whenever feasible the interviews were conducted face to face. If it was not possible to arrange a face to face meeting, the interview was conducted by telephone. Participants choosing to participate in a face to face interview were asked to identify their preferred location (the participant's home, Red River College, or a local coffee shop) for the interview to take place. A total of five face to face interviews were arranged, all of which were conducted in local coffee shops in Winnipeg, Manitoba. The remaining five interviews were conducted via telephone. The interviews were tape recorded to facilitate data transcription.

Data Collection Tools. Three data collection tools were developed. A questionnaire and two semi-structured interview guides.

Questionnaire development. The first step in the questionnaire development was to identify the concepts that would be addressed. According to Dillman et al. (2014), the concepts should flow directly from the overall purpose of the research and the objectives that have been identified. The purpose of this research was to explore and describe the integration of IENs into the nursing workforce on the Canadian Prairies. Before the development of the questionnaire began, a comprehensive search of the literature was undertaken and the factors that had been identified as associated with the integration of IENs into the nursing workforce were reviewed (see chapter two). Identified factors were then clustered into three main phases: Pre-migration (eg. migration decision, pre-migration education and work experience); becoming a nurse in Canada (eg. credential recognition and licensure requirements), and working as a nurse (eg. current workforce profile and match between credentials and employment). Additionally, as nursing workforce integration was conceptualized as a two way process, both characteristics of the IEN (eg. cultural, social, and economic capital) and characteristics of the host society (eg. policies, supports, and attitudes) were deemed important to explore.

Operationalization was the next step in the process and involved the development of specific questions designed to explore and describe each of the components of workforce integration (Biles et al., 2008). To accomplish this, each of the research objectives was listed

and the relevant concepts charted next to the objective. Indicators were then identified for each of the concepts following which the questions were formulated. In developing the questions, data collection tools from previous research on IENs and workforce integration were reviewed (Biles et al., 2008; Buchan et al., 2006; Cummins, 2009; Gupta, 2009; Lopez, 1990).

Permission from two authors was obtained to modify questions for use in this study. Cummins (2009) developed a questionnaire to examine the perceptions and attitudes of IENs toward integration into a perioperative practice setting. The original questionnaire contained 34 questions and included both open and closed ended responses. Fourteen of the questions that related to communication, assertiveness, delegation, level of support, and the host nurses' level of understanding and consideration of cultural needs were considered relevant to this research. With the authors' permission (Appendix B) these questions were adapted for use in this study. Likewise, Gupta (2009) developed a series of questions to examine racism and discrimination amongst nurses of colour in Canada. Eight of the questions examined the effect of race/ethnicity or colour on the hiring process, employment setting, work relationships, training and promotion opportunities, and performance reviews. Upon receiving permission from the author, the questions were adapted and included in the questionnaire (Appendix C).

Once the content for each of the questions had been determined, the next step was to choose the type of question to use. There were two broad categories to choose from, open ended and closed ended (Dillman et al., 2014). There are strengths and weaknesses associated with both question formats. While open ended questions allow a participant to freely answer a question in whatever manner they choose, survey respondents are more likely to skip open ended questions as they require more work to answer. Motivation to complete open ended questions can be enhanced by using this format sparingly and only when the collection of rich, detailed information is sought or little is known about a topic (Dillman et al., 2014).

Closed ended questions on the other hand are less work to answer; however, participants are forced to choose an answer which, in some cases, may not reflect an accurate response (Dillman et al., 2014). The addition of a "Don't Know" response on questions where it is plausible that respondents will not know an answer to the question, provides an option for those who cannot choose one of the fixed categories without having to provide an untrue answer (Dillman et al., 2014). A second option that can be used is a partially closed-ended question format. This format is a hybrid of open and closed ended questions whereby an "other" category is included along with the list of fixed responses. Thus participants are not restricted to the categories provided and can write in a more accurate response (Dillman et al., 2014). Surveys often contain multiple question formats and the format of each question

depends on the nature of the information to be collected (Dillman et al., 2014). Open ended, closed ended, and hybrid questions were included on the questionnaire.

A limited number of open ended questions were included on the questionnaire. Open ended questions were used for two reasons. First, they were used to explore areas where little was currently known about a topic. For example, the reasons IENs choose to work as LPNs and/or URHWs upon arrival to Canada were relatively unexplored, thus open ended questions were considered the best format to elicit the desired responses on these topics. Second, open ended questions were used to elicit detailed information about areas that might not have been captured by the fixed response questions. For example, one question asked participants to "Please use this space to state any other comments on your experience as an Internationally Educated Nurse in Canada or any other information which you feel is relevant." In this example the use of an open ended question allowed the participant to discuss any topic of importance to them that might not have been covered by any of the survey questions.

The majority of the questions on the survey were closed ended. Two formats of closed ended questions, nominal and ordinal, were used. Nominal questions were used when participants were being asked to compare a set of responses with no natural order (Dillman et al., 2014). For example, question 19 on the LPN survey asked "What stage of the registration process are you currently at? Please choose only one answer," and participants were required to choose from a list of steps in the registration process. While in this example participants were asked to choose only one answer, in other nominal questions participants could select multiple responses (Dillman et al., 2014). For example, one question on the LPN and RN survey asked, "how did you find out about your first nursing position as an LPN?" and participants were instructed that they could "check all that apply." Many of the nominal questions were designed in a hybrid format, including an "other" category at the end of the list (Appendix D) to allow participants to write in their own responses if none of the categories applied.

Ordinal questions were used when there was an ordered set of answer categories, where each category represented a higher or lower level but the interval between categories were not necessarily equal (Dillman et al., 2014). When designing ordinal questions researchers have the option of choosing from two main types, unipolar or bipolar. Unipolar ordinal questions "measure gradation along one dimension where the zero point falls at one end of the scale" (Dillman et al., 2014, p. 151), whereas bipolar ordinal questions "measure gradation along two opposite dimensions, with the zero point falling in the middle of the scale, or where it tips from positive to negative" (Dillman et al., 2014, p. 151).

The decision to use a unipolar or bipolar format depends on the nature of the construct. In the concepts explored in this research, both the direction (positive or negative) and the magnitude (how positive or how negative) were considered important; therefore, a bipolar question format was used (Dillman et al., 2014). For example, one question asked participants to *"please rank how difficult it was to meet the financial requirements listed below"* on a five point scale from very difficult to very easy with a neutral mid-point. A five point scale was chosen as, according to Dillman et al. (2014), the optimal scale length is between five to seven categories which allows for two to three levels of differentiation on either side of the neutral mid-point. Each of the categories was fully labeled to reduce the context effect that can occur with the interpretation of unlabelled categories (Dillman et al., 2014).

The questions that were based on the work of Cummins (2009) were also modified at this time. In the original survey Cummins used a five point Likert scale: Strongly Disagree, Disagree, Don't Know, Agree, and Strongly Agree. Dillman et al. (2014) recommend that undecided responses are not comparable to neutral responses and therefore should not be used as a midpoint. Instead they recommend placing the undecided responses, such as "don't know" at the end of the scale. Therefore, the neutral response, Neither Agree or Disagree, was placed at the mid-point and the Don't Know response was placed at the end of the scale.

Online survey design. Once the questions were finalized, the next stage was to create the online survey. The research and planning department at Red River College (RRC), in collaboration with the researcher, designed the online survey utilizing the survey system Vovici. The online survey was developed over a period of four months, during which time the researcher worked closely with the survey design specialist from RRC. The expertise of the survey design specialist was invaluable in creating the visual layout of the online survey. Each page of the survey was formatted to ensure the questions were clear, the text was legible, the navigation buttons were visible, and the overall look of the survey was visually pleasing (Dillman et al., 2014).

Significant time was also spent establishing the navigational path for the survey. Throughout the survey, certain responses would trigger a particular pathway, while other responses would trigger an alternate pathway. For example, Question 18 on the survey was only asked of LPNs (see Figure 5), and the navigational path for a **yes** response would take the participant to the next question, while the navigational path for a **no** response would skip the next set of questions and take the participant directly to question 22. Determining the correct navigational path and ensuring the accuracy of the programming was an integral part of the survey design (Dillman et al., 2014).

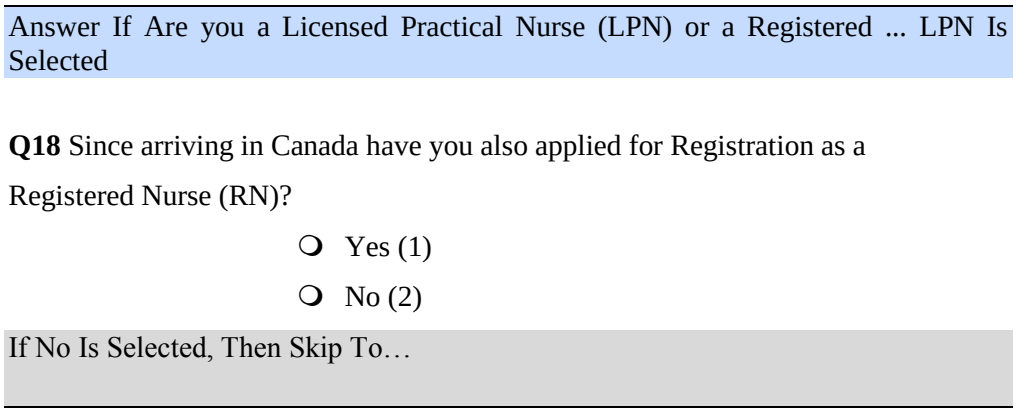

Figure 5. Navigation path online survey.

In determining the navigational path it was also important to decide if respondents should have the ability to move backwards in the survey. While an important component in survey design is to keep participants moving forward, it was felt that allowing respondents an opportunity to revisit previous questions to correct or add information would contribute to data quality (Dillman et al., 2014). Finally, the design and programming of an online survey can require participants to answer every question or allow participants the option to skip questions and still proceed with the survey. While allowing participants to skip questions may result in some missing data, the alternative of requiring responses before participants can move to the next questions has been found to have detrimental effects on participant motivation and may decrease the likelihood that the participant will complete the survey (Dillman et al., 2014). Therefore, with the exception of the first four qualifying questions that were required to ensure participants met the inclusion criteria and a small number of questions that required an answer to reroute participants to the appropriate follow up questions, the survey was programmed to allow participants to move forward without responding to every question.

Once the survey design and programming was complete, the online survey was tested and re-tested by the researcher. According to Dillman et al. (2014), "Testing the web survey is one of the most important steps in the design process" (p. 344). Every page and survey question was tested to ensure the navigational pathways, the number of answers a participant could select on each question (i.e. select all that apply or select only one answer), and the layout of the survey were correct. The results of the initial testing detected a number of programming errors. After these errors were rectified the survey was re-tested. The testing and re-testing continued until no errors were detected.

Interview guides. A topic guide, comprised of a list of questions or topics to be discussed during the semi-structured interviews with RN and LPN participants, was developed (Polit & Beck, 2016). The topics were organized into three main themes: migration to Canada, becoming a nurse in Canada, and working as a nurse in Canada. Under each theme, a series of guiding questions were prepared to ensure all areas were covered with each participant (Polit & Beck, 2016). The questions were open ended and were designed to elicit in-depth responses from participants. Probes were included to encourage more detailed information (Polit & Beck, 2016). For example, the question *what factors led to your decision to work as a LPN in Canada,* may have been followed with the probe, *Can you tell me more about…* to try and generate richer responses. Several of the topics covered during the semi-structured interview were also addressed on the online survey; however, the interview provided an opportunity for participants to talk freely and discuss their experiences in their own words (Polit & Beck, 2016).

A semi-structured interview guide was also developed for the interviews with URHWs. This interview guide contained both open and closed ended questions. The questions on pre-migration education and work experience, reasons for migration, racism and discrimination, and demographic profile were fixed response or partially closed ended formats and were the same as the questions included on the online survey. In addition, a series of open ended questions, with accompanying probes, were included and provided an opportunity to explore topics that were poorly understood (Polit & Beck, 2016). Questions explored participants' reasons for working as URHWs, their intention to seek licensure as regulated nurses in Canada, and the challenges and supports they encountered. Both interview guides have been included in Appendix E.

Section Five: Data Quality

To make a worthwhile contribution to the body of knowledge in a particular field, research studies need to be rigorously conducted (Merriam & Tisdell, 2016). While there is agreement amongst scholars on the importance of ensuring the quality of research, there is ongoing debate about what constitutes rigour and the best approach to attain it (Collins, 2015). Differences in philosophical assumptions between qualitative and quantitative paradigms have led to the development of different criteria and language for assessing and discussing quality in each research approach (Merriam & Tisdell, 2016). In quantitative research rigour is generally assessed through measures of reliability and validity, whereas in qualitative research 'authenticity' or 'trustworthiness' is most frequently assessed through the concepts of

credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). Assessing quality in mixed-methods research has also been widely debated in the literature (Bryman, 2006/2008; Collins, 2015; Onwuegbuzie & Johnson, 2006/2008) and currently no consensus exists amongst scholars on the best criteria to apply to mixed-methods research (Morse, 2010).

In reviewing the literature, the three forms of validity designs developed by Bryman (2006/2008) were considered most useful in assisting the researcher to determine the most appropriate criteria to apply to this study. Bryman (2006/2008) identified three forms of quality criteria for mixed methods research: separate criteria, convergent criteria, and bespoke criteria. Separate criteria involve the application of the quality criteria associated with each method. Thus, quantitative measures of reliability and validity are applied to the quantitative component and qualitative measures of authenticity and trustworthiness are applied to the qualitative strand. The application of separate criteria is appropriate when the data collection and analysis for each component occurs separately and integration of the qualitative and quantitative findings occurs at the conclusion stage of the study (Collins, 2015). Convergent criteria, on the other hand, apply the same criteria to both the qualitative and quantitative components (Bryman, 2006/2008). Convergent criteria are generally applied when a researcher is working from a single paradigm, either quantitative or qualitative (Collins, 2015). Finally, bespoke criteria are quality criteria developed specifically for mixed-methods research and address the whole study rather than the individual qualitative and quantitative components within it (Morse, 2010). Bespoke criteria are most appropriate when a high level of integration exists, for example, in studies that utilize an integrated approach to both data collection and analysis (Collins, 2015).

This study utilized a concurrent design with a parallel approach to data analysis, whereby qualitative and quantitative analyses occurred independently and the integration of findings took place after the analysis of each component was complete. Therefore, the application of separate criteria was considered most appropriate. Measures of reliability and validity were considered when designing the quantitative component and the concepts of credibility and consistency (Merriam & Tisdell, 2016) were applied to the qualitative component.

Data quality: Questionnaire. A pilot-project assessing the data quality of the questionnaire was conducted. Through the pilot, the content validity as well as the readability, flow, format, and clarity of the questions on the questionnaire was established. In addition, the reliability of questions on racism and discrimination, adapted from the work of Gupta (2009) was established.

***Content validity*.** Polit and Beck (2017) define content validity as "the extent to which an instrument's content adequately captures the construct – that is, whether an instrument has an appropriate sample of items for the construct being measured" (p. 310). Three issues, important in content validation, have been identified: relevance to the construct being examined, comprehensiveness to ensure no notable omissions of content, and the balance of questions on the different domains (Polit & Beck, 2016). Researchers designing a new questionnaire should begin with a thorough review of the literature and consult with both experts and members of the target population. These consultations can provide important information and assist the researcher to establish if there is adequate content coverage (Polit & Beck, 2016).

Prior to distributing the online survey the questions were reviewed by three sources. First, the researcher's supervisor, an expert in the area of nurse migration, evaluated and provided valuable feedback on the content of the questionnaire. Second, a pilot of the questionnaire was conducted with two groups of IENs. The first group was comprised of members of the Executive Board for the Philippine Nurses Association of Manitoba (PNAM). The PNAM executive was chosen to pilot the questionnaire for two reasons. Firstly, all members of the executive were IENs from the Philippines and therefore had first-hand knowledge of the transition into the Canadian nursing workforce. And secondly, one of the main functions of the PNAM was to provide support to IENs from the Philippines who migrate to Canada. In providing this support, they have developed extensive knowledge of the challenges IENs encounter integrating into the Canadian nursing workforce. The second group who participated in the pilot were IENs enrolled in the Bridging Program for IENs (BPIEN) at Red River College (RRC) in Winnipeg, Manitoba. IENs who had completed their entry level nursing education in the Philippines and had formerly been registered as RNs in the Philippines were recruited to the pilot. The inclusion criteria were established to ensure pilot participants were similar to the target population.

Pilot project stage one: PNAM. An email invitation was sent to the President of the PNAM inviting members of the executive to participate in the pilot. Five members of the executive agreed to participate; however, on the day the pilot project interview was scheduled, there was a severe snow storm in Winnipeg and only four participants were able to attend. The interview was held in February 2013 in the home of one of the executive members. Overall, participants stated that the questions on the survey were comprehensive and adequately

covered the content/concepts associated with workforce integration. A number of minor revisions to the questionnaire were suggested.

First, participants recommended removing the option Diploma in Nursing from the responses provided in the question: *What University/College degree(s) did you obtain the Philippines? Check all that apply*. The participants noted that the last diploma program closed in the Philippines in 1978 and therefore, very few, if any, participants would require this response. As the option *other* was included to capture any additional answers, the diploma response was removed from the final questionnaire.

Second, participants suggested an additional answer be added to the responses for the question: *What is your current immigration status in Canada?* The original responses included the option *landed immigrant* but did not include *permanent resident.* In Canada, the terminology "landed immigrant" and "permanent resident" are frequently used interchangeably, thus the fixed response was changed to *landed immigrant/permanent resident.*

Third, participants recommended the addition of a follow up question to the question: *Which of the following best describes the practice setting you worked most often as a RN before moving to Canada*? Participants noted that in addition to the work setting, it was important to know the position/role the IEN occupied before migration. Therefore, a follow up question regarding job title prior to migration was added to the final survey. Finally, the racism and discrimination scale on the pilot survey asked for a yes/no response. The consensus amongst the pilot participants was that the answers to these questions were not absolute. A strong recommendation was made to place these items on a Likert scale, allowing respondents a range in responses.

Pilot project stage two: BPIEN. The lead instructor for the BPIEN read an announcement to all enrolled students inviting them to participate in the pilot project. At the time the pilot was conducted, 23 students were enrolled in the program, 18 met the eligibility criteria and of those, 11 agreed to participate. One session was held in March 2013. Pilot project participants were asked to first complete the written questionnaire and then participate in a focus group interview. During the focus group interview, participants were asked to comment on the readability, flow, format, clarity, and content of the questionnaires (Appendix F).

Overall, the pilot participants felt the flow, format, readability, and clarity of the questionnaire was good, and all participants completed the questionnaire without any clarification from the researcher. Participants felt the content covered in the questionnaire was comprehensive and offered no recommendations for additional questions. While the majority

of feedback provided was positive, participants did suggest revisions to a number of questions on the survey.

First, a few minor wording changes were recommended. For example, the question: *When did you first **join** the register as a Registered Nurse (RN) in Canada?* (*i.e. Become an RN)* was confusing. The phrase "join the register" was unfamiliar to participants and it was suggested that the question be reworded by placing the "cue" – (become an RN) in the stem of the question. Based on this feedback the question was reworded as follows: *What year did you first become a Registered Nurse (RN) in Canada? (i.e. Join the register as a RN).*

Second, on the pilot questionnaire two questions were included on pre-licensure supports. The first question asked participants **who** provided information and support and the second question asked **how helpful** each source was in providing information and support. The options for both questions (i.e. the nursing regulator, the nursing union, family, friends, etc.) were the same. Based on the feedback provided by participants a decision was made to delete the first question and only include the second question in the final questionnaire.

Third, several of the questions that had been adapted from the questions developed by Cummins (2009) required review. The original questionnaire included six statements that focused on *verbal communication*. The comments provided during the focus group interview demonstrated that a number of participants were uncertain of the concept these statements were measuring. Participants noted that the first two statements on *Verbal communication with patients/family members* were unclear. Participants were unsure if the statements were asking about their ability to speak with patients and families in English (language skills) or about their ability to use the therapeutic communication skills emphasized in Canadian nursing practice.

Upon receipt of this feedback, a review of the literature was undertaken to determine which aspect of patient and family communication was more important to examine. While technical language skills were identified as important, the results of the literature review revealed that effective communication with patients and families extends well beyond fluency in the English language (Allan & Westwood, 2016; Baumann, Blythe, & Ross, 2010; Lum et al., 2015; Tregunno et al., 2009). The use and interpretation of body language, as well as the ability to engage and respond empathetically are required (Duff et al., 2002). These aspects of communication are more accurately reflected in the concept of *therapeutic communication* and thus the wording of these two statements was changed to reflect this. Participants also noted that the four statements on *Verbal communication with [other nursing staff/doctors/interdisciplinary team/support staff]* were unclear. Participants were uncertain if the statements were asking about English language skills or the level of assertiveness

required when communicating with other health professionals. The results of the subsequent review of the literature emphasized the significance of assertiveness when communicating with members of the interdisciplinary team (Begley, 2010; Lin, 2009); therefore, the decision was made to change the wording to *Communicating in an assertive manner with [other nursing staff/doctors/interdisciplinary team/support staff]*. While these six statements were changed to reflect therapeutic and assertive communication skills, technical language skills continued to be examined through the two statements on *English language* and *accents* included on the questionnaire.

Reliability. While the majority of the questions on the questionnaire were designed to generate descriptive data about the integration of IENs into the workforce, two sets of questions consisted of multiple items that were related: the questions on racism and discrimination (Gupta, 2009) and the questions on attitudes toward integration (Cummins, 2009). Based on the feedback received from the PNAM executive, each of the items on racism and discrimination (Gupta, 2009) was placed on a 5 point Likert scale ranging from Strongly Disagree (1) to Strongly Agree (5). Before using the scale, it was important to assess the internal consistency on the revised tool (Pallant, 2013). Therefore, during stage two of the pilot, the revised tool was completed by the BPIEN pilot participants. The Cronbach alpha coefficient for the revised Racism and Discrimination scale in this pilot was 0.88. Although this coefficient was calculated based on the results from a very small sample (n=11), the score was above a Cronbach alpha, 0.8 which is deemed a minimum accepted value for internal consistency (Polit & Beck, 2016); therefore, the decision to include the revised format on the final questionnaire was made.

Data quality: Qualitative strand. The credibility and consistency of qualitative data were the key methods used to ensure the quality of the qualitative data collected.

Credibility. In determining the quality of qualitative research, it is important to consider if the findings and subsequent interpretations were *credible* given the data presented (Lincoln & Guba, 1985; Merriam & Tisdell, 2016). Two strategies were undertaken to increase the *credibility* of the qualitative findings for this study: adequate engagement in data collection, and triangulation (Merriam & Tisdell, 2016).

Determining how many interviews are needed to gain an adequate understanding of a particular phenomenon is a difficult question to answer. The presence of data saturation is considered one of the best strategies to ensure adequate engagement in data collection

(Merriam & Tisdell, 2016). As previously discussed in this chapter, 22 interviews were conducted with RN and LPN participants and data saturation was achieved. Although saturation was not fully reached during the 10 URHW interviews, the additional data from the qualitative responses of 70 survey participants provided corroboration that adequate data was collected.

Triangulation of methods was also utilized to increase the credibility of the study findings. In purely qualitative studies, the triangulation of methods involves the use of two or more qualitative methods for data collection (Merriam & Tisdell, 2016), however, in mixed-methods research, triangulation of methods can also include the use of additional quantitative methods (Creswell et al., 2003/2008). In this study, two forms of qualitative data were collected: interviews and open ended responses to survey questions. For example, the factors that led to the decision to work as a LPN were explored both during the telephone interviews and through an open ended question on the survey. By validating the data from one method with data from the other, the overall credibility of the findings was enhanced (Merriam & Tisdell, 2016). In addition, data obtained through the qualitative interviews were also corroborated with data obtained through quantitative questions on the survey. By illustration, throughout the qualitative interviews participants frequently identified that completing the clinical competence assessment (SEC/CCA) was one of the main challenges encountered in the pre-licensure period. This finding was validated through the quantitative findings which revealed that 69% of RNs and 91% of LPNs who had undergone an assessment reported it was difficult or very difficult to complete the SEC/CCA.

Consistency. How consistent the results of a study are in relation to the data collected is an important measure of quality in qualitative research (Merriam & Tisdell, 2016). As Merriam and Tisdell (2016) explain, it is important that other researchers "concur that, given the data collected, the results make sense - they are consistent and dependable" (p. 251). In order to make this determination there is a need for transparency in the data analysis process so others can ascertain how categories were formed and how decisions were made (Merriam & Tisdell, 2016). To enhance transparency the 'Framework' method of analysis (Ritchie & Spencer, 1994) was chosen as the approach for qualitative data analysis in this study. One of the key strengths of Framework Analysis (FA) is that it provides a systematic approach, consisting of five established analytical stages, that allow other researchers and reviewers to determine how the final interpretations were derived (Furber, 2010). In addition, the use of a charting matrix provides enhanced transparency in the coding process and can provide a clear record of how the data moved from transcript to theme (Dixon-Woods, 2011).

In addition, peer review is another strategy that can enhance consistency (Merriam & Tisdell, 2016). Two forms of peer review were undertaken. First, all stages of the research process, from design to analysis, were reviewed by the writer's Director of Studies. This review provided important guidance and ensured appropriate approaches were utilized for data collection and analysis and the conclusions drawn were reasonable. Second, three abstracts for paper presentations and one abstract for poster presentation were accepted following a peer review process at four national conferences. Each conference had researchers and faculty in attendance, who work closely with IENs. The preliminary findings for different areas of the results section were discussed at each presentation. Following the presentations, feedback from colleagues indicated that the findings "rang true" and were consistent with their experiences with IENs. However, the discussion following one of the first presentations, which focused on post-employment challenges, highlighted how the title chosen for one of the sub themes could be misinterpreted. The researcher had originally used the titled "learning the Canadian way", which was a direct quote from one of the participants. One of the conference attendees, an expert in IEN bridging education and integration research, passionately argued that this implied that there was only *one right* Canadian way, which she did not believe was the conclusion intended. After reflecting on her comments the title of the sub-theme was changed to "adjusting to nursing practice in Canada".

Section Six: Ethical Considerations

In conducting any research study, protecting the rights of project participants is of prime concern. Prior to beginning the research project, ethical approval from the Queen Margaret University (QMU), Edinburgh, Scotland ethical review board was obtained (Appendix G). Upon receipt of approval from QMU, a second ethics proposal was submitted to Red River College (RRC), Winnipeg, Manitoba to seek permission to pilot the questionnaire with students enrolled in the Bridging Program for Internationally Educated Nurses at RRC. Ethical approval was granted (Appendix H).

Informed consent. Before beginning a face to face or telephone interview, participants were asked to provide informed consent. An information sheet explaining the research was provided (face to face interviews) or read (telephone interviews) to potential participants. The researcher then asked participants if they had any questions. Once all questions had been answered, and if participants agreed to participate, either a signed consent (face to face) or verbal consent (telephone) was obtained. Furthermore, an information sheet was provided on

the first page of the online questionnaire. The completion and submission of the questionnaire indicated consent to participate in the research. A sample of the information sheet and informed consent form has been included in Appendices I and J.

Survey software. In order to ensure maximum protection of data from the online survey, the Vovici survey software, utilized by the Research and Planning department at RRC was used for this project. A letter, written by Ashley Blackman, the Director of Research and Planning at RRC, outlining the security and privacy provisions that were in place has been included in Appendix K.

Section Seven: Data Analysis

A parallel approach to data analysis was undertaken. Qualitative and quantitative data were analyzed independently and brought together once the analysis of each component was complete. After each data set had been analyzed independently, the quantitative findings were reviewed and interpreted alongside the corresponding qualitative findings and the results were integrated in the writing of the results narrative (Dahlberg et al., 2010; Morse, 2015). The following section will discuss the processes undertaken in conducting the data analysis.

Quantitative data analysis. Quantitative analysis is "the manipulation of numeric data through statistical procedures for the purpose of describing phenomena or assessing the magnitude and reliability of relationships among them" (Polit & Beck, 2012, p. 739). To conduct the quantitative analysis the data from the questionnaire was uploaded into IBM SPSS statistics software (SPSS)® by the Research and Planning department at RRC. The first step undertaken by the researcher was to prepare a code book. The code book included a list of the variable names as well as the value labels for each of the possible responses (Pallant, 2013). Each question in the survey was assigned a unique variable name and each response was assigned a numerical code (Pallant, 2013). For example, the variable Question 3 *are you an LPN or RN?* had three possible responses and each of the responses was assigned a numerical label (see Figure 6)

/Q3"Are you a Licensed Practical Nurse (LPN) or Registered Nurse (RN)?

1"LPN"
2"RN"
3"None of the Above

Figure 6. Survey question sample.

Preliminary analysis. The first step in the preliminary analysis was to screen the data for incomplete surveys and missing data. A total of 293 IENs opened the survey link. Of these, 73 did not complete the survey. An additional 48 did not meet the eligibility criteria: 40 arrived in Canada prior to 2008, 6 were not currently a RN or LPN, and 2 had not previously been registered as a RN in the Philippines. The data from these 121 participants were removed, and the final data set consisted of 172 participants that included 84 RN's and 88 LPNs from each of the three Prairie Provinces: Alberta, Saskatchewan, and Manitoba. Of the 172 remaining participants, the majority completed all the fixed response questions in the survey. However, some participants chose to skip questions and therefore there were some missing data in the file. Before beginning the analysis it was important to decide how to manage missing data. Within SPSS there were two options that were considered. The first option was to 'Exclude cases listwise,' which would exclude any case from the analysis with an incomplete data set (Pallant, 2013). This option was considered and rejected as it was thought it would unnecessarily reduce the sample size even further (Pallant, 2013). The second option was to 'Exclude cases pairwise,' which would exclude the participant only if the data required to conduct the specific analysis was missing. In this option cases were still included in any analysis where the data were provided (Pallant, 2013).

The second step in the preliminary analysis was to review all of the survey questions and responses for data quality. Upon review, the question *how helpful was the bridging program in helping you become a RN/LPN in Canada*, was removed from the analysis as it had been incorrectly worded on the survey. Instead of providing participants with a 5 point scale, with a neutral option at the mid-point, a four point scale was provided. The neutral mid-point had been inadvertently omitted. As this format was not the intended design, the question was removed from the analysis. In addition, the responses to the question examining the type of pre-migration work experience asked participants how long they had worked in each position. The options included 0-6 months, 6 months to 1 year, 1 to 5 years and more than 5 years. The wording of the responses meant there was some overlap in the categories as participants who had worked for 6 months or 1 year could provide a response in more than one category. Rather

than eliminating the question, a decision to combine the first three categories in the analysis was made thus eliminating any overlap in responses.

Next, the reliability of the racism and discrimination scale was determined. As the internal consistency of the scale on the small sample (n=11) participating in the pilot project can vary significantly depending on the sample (Pallant, 2013), the internal consistency of the scale was calculated once again before completing the data analysis. The Cronbach alpha coefficient for the racism and discrimination scale with the study sample was 0.95, which indicated good internal consistency (Polit & Beck, 2016).

Finally, the reliability of the set of questions on workforce integration, modified from the work of Cummins (2009), was determined. Cummins (2009) had reported a Chronbach's Alpha of 0.89 for the original instrument. However, as significant modifications to questions were made during the pilot project, it was important to assess reliability on the revised scale. Before the reliability of the scale could be assessed, a number of items were reversed within SPSS so that all items were scored in the same direction (Pallant, 2013). Once completed, the internal consistency for the current study, based on 15 items, was calculated. A Chronbach's Alpha of 0.80 was established, which met the minimum accepted value for internal consistency (Polit & Beck, 2016).

Statistical analysis. The next stage in the quantitative analysis was to apply descriptive statistics to the quantitative data. Descriptive statistics were used to describe and synthesize data (Polit & Beck, 2016). Frequency distributions were the primary descriptive statistic used to calculate how many participants provided a certain response (Kim & Mallory, 2017). The frequencies were computed through SPSS and were then organized and displayed in tables, histograms, and graphs.

Two group comparisons were conducted for a number of variables. A Chi-square test for independence was used to explore relationships between two categorical variables (Kim & Mallory, 2017). For example, a Chi-square test for independence was used to examine differences that may exist between the numbers of RN versus LPN participants who had children, as well as the number of RN versus LPN participants who currently worked in a long term care (LTC) setting.

The chi-square test is a nonparametric test that "compares the observed frequencies or proportions of cases that occur in each of the categories, with the values that would be expected if there was no association between the two variables being measured" (Pallant, 2013, p. 225). To calculate a Chi-square test for independence using SPSS, a contingency table showing the

relationship between the two categorical variables was first created. An example of a 2 X 2 table is provided in Table 1.

Table 1. Contingency Table – Work Setting

Designation	Work in LTC	Do not work in LTC	Total
RNs	12	72	84
LPNs	27	54	81
Total	39	126	165

To apply the Chi-square test for independence the following assumptions had to be met. First, all observations had to be independent. Second, the expected frequency within each cell had to be greater than one, and finally, no more than 20% of the cells had a value of less than 5 (Kim & Mallory, 2017). However, at times the latter two assumptions could not be satisfied. For example, when examining the differences in employment status between RNs and LPNs, the reported cases in one cell was 0 and in another 7. In this case, the Fisher's exact test was the most appropriate statistic to calculate (Hassard, 1991).

In deciding what statistical test to utilize to explore differences between two groups for continuous variables, the researcher has to first choose between parametric and non-parametric tests. To apply parametric tests two main assumptions have to be satisfied. First, the data has to be measured on an interval or ratio scale and second the data has to follow a normal distribution. Normality can be assessed using the Explore functions within SPSS. This procedure was undertaken for each of the variables and the scores did not fall into a normal distribution. This finding is not uncommon within social science research as results can be positively or negatively skewed if the majority of participants answer a particular response in one direction, for example, if the majority of participants strongly agree or agree with a particular statement (Pallant, 2013). When samples do not follow a normal distribution, one option that can be carried out is to transform the data though statistical procedures (Hassard, 1991). However, data transformation was not considered as the first assumption was also violated.

Within this study the data for continuous variables were measured on an ordinal scale. The questions asked participants to choose a response in one of five ordered categories. The categories were ranked to show a magnitude of change. For example, a participant who answered that a particular support was very helpful perceived more helpfulness than a participant who responded that it was quite helpful; however, on an ordinal scale the degree of change between categories is not necessarily equal and it was therefore not reasonable to calculate a mean and standard deviation (Hassard, 1991). Non-parametric tests are considered most appropriate for use with ordinal data (Kim & Mallory, 2017) and were thus applied for data analysis in this research. When interpreting the findings of non-parametric tests it is important to note the following limitation: Non-parametric tests are less powerful than parametric tests; therefore, the possibility of making a type II error, failing to detect a significant difference between groups, is higher (Hassard, 1991). The non-parametric test used for comparing two independent samples was the Mann-Whitney U test (Kim & Mallory, 2017). The Mann-Whitney U is the non-parametric equivalent to the t-test for independent samples and instead of comparing means of the two groups, it compared medians (Pallant, 2013). The Mann-Whitney U was calculated using SPSS.

Qualitative data analysis. Qualitative data analysis is the process used to make sense of the qualitative data collected during a study. It involves consolidating, reducing, and interpreting the data to provide some coherence or structure while remaining true to the participants' original accounts (Merriam & Tisdell, 2016; Ritchie & Spencer, 1994). Multiple approaches to qualitative data analysis have been discussed in the literature (Corbin & Strauss, 2008; Merriam & Tisdell, 2016; Ritchie & Spencer, 1994). The varied approaches reflect different analytic levels and the findings range from simple descriptive accounts to higher level abstractions in the form of models or theories (Merriam & Tisdell, 2016). As Saldaña (2013) notes, there is no one "*right*" or indeed "*best*" way to analyze qualitative data, but rather the most appropriate method of analysis is dependent upon the philosophical perspectives, research questions, and methodologies undertaken. As previously discussed, the qualitative component of this mixed methods research utilized a qualitative descriptive approach. In this approach the analysis of data is viewed through an analytic lens that keeps the interpretation "*data near*" (Sandelowski, 2010, p.78), and the findings provide a detailed description of the data in a format that is "minimally theorized or otherwise transformed" (Sandalowski, 2000, p. 337).

Framework analysis. The 'Framework' method of analysis was originally developed in the United Kingdom for use in applied social policy research (Ritchie & Spencer, 1994). In recent years it has been increasingly utilized in health research (Gale, Heath, Cameron, Rashid, & Redwood, 2013; Ward, Furber, Tierney, & Swallow, 2013) and to conduct the qualitative analysis in mixed methods studies (Dale et al., 2015; Evans, Wood, & Carter, 2016). Framework Analysis is not aligned with a particular epistemological or philosophical paradigm. Rather it is a flexible method of thematic analysis that can be utilized with many qualitative approaches (Gale et al., 2013). Framework Analysis is well suited to conduct the thematic analysis of semi-structured interview data and the outcome of the analysis can provide a full description of phenomena (Gale et al., 2013). Therefore, the 'Framework' method of analysis is consistent with the aim of the qualitative descriptive approach and was considered the best approach to data analysis for this research study.

Framework Analysis provides a structured and rigorous process for conducting data analysis while maintaining the flexibility required to identify and characterize themes that emerge from the data (Dixon-Woods, 2011). According to Ritchie and Spencer (1994), the 'Framework' method of analysis has a number of key features:

- *Grounded or generative:* It is heavily based in, and driven by, the original accounts and observations of the people it is about.
- *Dynamic:* It is open to change, addition and amendment throughout the analytic process.
- *Systematic:* It allows methodological treatment of all similar units of analysis.
- *Comprehensive:* It allows a full, and not partial or selective, review of the material collected.
- *Enables easy retrieval:* It allows access to, and retrieval of, the original textual material.
- *Allows between- and within-case analysis:* It enables comparisons between, and associations within cases to be made.
- *Accessible to others:* the analytic process, and the interpretations derived from it, can be viewed and judged by people other than the primary analyst. (p.176)

The 'Framework' method involves five distinct yet interconnected stages: familiarization, identifying a thematic framework, indexing, charting, and mapping and interpretation (Ritchie & Spencer, 1994). Although the steps in this approach are highly systematic, it is not purely a mechanical process. The creative and analytic skills of the researcher are paramount to derive meaning and salience from the data (Ritchie & Spencer, 1994).

Stage one: Familiarization. Familiarization is the process of becoming increasingly familiar with the qualitative data that has been collected. The intent is to become immersed

in the data, to gain an awareness of the entire data set, before beginning to divide the data into recurring themes (Richie & Spencer, 1994). Familiarization can occur through the process of data transcription, reading the interview transcripts, or re-listening to the tape recorded interviews (Lacey & Luff, 2009). Familiarization of the data was undertaken in this study in three ways. First, after each qualitative interview was conducted, the researcher transcribed verbatim the tape recorded transcript. Although this process was time consuming, it enabled the researcher to become aware of the details of each interview and to hear the expression in the participants' voices as they described their experiences. Second, once the interviews were fully transcribed the researcher read and reread each transcript. By reading each transcript in its entirety, the researcher became familiar with the "*whole*" story as told by each participant before beginning to divide the data into themes. Finally, the qualitative comments provided by participants on the online survey were "cut" and "pasted" into a word document. One document was created for each of the qualitative questions which allowed the researcher to review all the responses for an individual question in one location.

Stage Two: Identifying a thematic framework. The second stage in Framework Analysis is to identify a thematic framework. During this stage the researcher returns to the data and attempts to identify key concepts and themes (Ritchie & Spencer, 1994). In constructing the thematic framework, the analyst draws upon both *a priori* themes, pre-selected based on the literature, informed by the original research aims and included in the interview guide, and *de nova* concepts generated from recurring concepts identified through open coding (Dixon-Woods, 2011; Gale et al., 2013; Ritchie & Spencer, 1994). According to Ritchie and Spencer (1994), the first version of the thematic framework is often heavily rooted in *a priori* themes. In this study the initial *a priori* themes were guided by the concepts identified during the review of the literature that were reflected in the research questions. As the data was reviewed, these preliminary question based codes were applied. These question based codes or "structural" codes acted as a labeling and indexing device that allowed the researcher to identify large segments of text on broad topics (Saldaña, 2013). These large segments then formed the basis for more in depth analysis within and across topics (see Table 2).

Table 2. A Priori Themes -Initial Thematic Framework

Research Question	Themes
Examine the factors that influence the Philippine nurse's decision to migrate to Canada.	Migration decision
Explore the factors that influenced the Philippine nurse's decision to work as a Licensed Practical Nurses (LPN's) or Unregulated Health Worker (URHW) in Western Canada.	Decision to work as a LPN Decision to work as a URHW Match between pre-migration qualifications and post-migration employment
Explore the challenges that nurses from the Philippines encounter while entering and integrating into the Western Canadian nursing workforce.	Pre-licensure challenges Post-employment challenges
Describe the supports that nurses from the Philippines utilize while entering and integrating into the Western Canadian workforce.	Pre-licensure supports Post-employment supports

Once the initial thematic index is developed it is then applied to a few transcripts and the framework becomes more refined as additional themes emerge from the data (Ritchie & Spencer, 1994). In this study, several of the large segments of data that had been organized in accordance with the structural codes were further analyzed using 'open coding' and additional descriptive codes were identified. Descriptive codes summarized in a word or short phrase the central topic of a passage or narrative (Saldaña, 2013). Descriptive codes were chosen as they stay close to the data and assist in describing what participants say in a format that is minimally transformed (Saldaña, 2013). The process of developing the thematic framework was both time consuming and challenging. The complexity of this stage of analysis is captured in the words of Ritchie and Spencer (1994), "Devising and refining a thematic framework is not an automatic or mechanical process, but involves both logical and intuitive thinking. It involves making judgements about meaning, about the relevance and importance of issues, and about implicit connections between ideas" (p. 180). An example of the index developed for the theme *post-employment challenges* is provided in Figure 7.

Index (Descriptive Codes)

Post-Employment Challenges

- 6.1 Procedures & Protocols
- 6.2 Skills
- 6.3 Knowledge
  - Health Assessment
  - Medications
  - Equipment & Technology
  - Client populations
    - Indigenous
    - Geriatric
- 6.4 English Language skills
- 6.5 Accent of others
- 6.6 Idioms
- 6.7 Communication with patients
- 6.8 Communication with families
- 6.9 Communication with IDT
- 6.10 Assertiveness
- 6.11 Delegation
- 6.12 Patient: Nurse Ratios
- 6.13 Sick Calls
- 6.14 Health Care Funding -Canada
- 6.15 Health Care Funding - Philippines
- 6.16 Different Approach to Care:
  - Elder Care
  - Pain Management
  - Palliative Care
- 6.17 Hours of work
- 6.18 Endorsements
- 6.19 Scope of practice
- 6.20 Interdisciplinary practice
- 6.21 LPN vs RN responsibilities
- 6.22 Racism/Discrimination
- 6.23 Bullying

Figure 7. Index: Theme 6 - Post-Employment Challenges

Stage three: Indexing. Indexing or coding refers to the process of applying the index to the data in its textual form (Ritchie & Spencer, 1994). Codes are applied to identify data that correspond to the differing themes and sub-themes (Lacey & Luff, 2009). Saldaña (2013) described coding as the initial step, a transitional process between the data collection and its interpretation. Coding is more than simply labeling the data; it links the data to the idea (Richards & Morse, 2007; Saldaña, 2013). It is a method that organizes and groups similarly coded data into categories that share certain characteristics (Saldaña, 2013). All coding is conducted through a filter, and how the researcher perceives and interprets data is influenced

by the type of filter applied to the analytic lens (Saldaña, 2013). The process of indexing is subjective and the judgements made are open to differing interpretations. By adopting this system of indexing however, the process of how the data is coded and organized is transparent and visible to others (Ritchie & Spencer, 1994).

To prepare the data for coding the transcripts were formatted using Microsoft Word. Each transcript was double spaced with a wide right margin to allow space for writing codes. All the qualitative data collected was included for coding to ensure the data was sufficient not just in quantity but quality and that all relevant text was considered (Saldaña, 2013).

The following short passages provide an example of the indexing or coding process. While in both dialogues the participants discussed medications, the context of each discussion was notably different. In the first passage the focus was on medication knowledge, whereas in the second, the emphasis was on how medications, in this case narcotics, were utilized to provide a different approach to pain management.

Post-employment challenges:

> "Well um of course the medications, there are a lot of medications that I am studying here, in the Philippines um there is not much. I haven't experienced a variety of you know medications because I only worked in a public hospital – it's 100 bed capacity but it's not a tertiary hospital, so it's not that much complicated... I find the medications here challenging – of course I've encountered them during nursing school but some of the medications are new. [Joan, LPN]
>
> [6.3] KNOWLEDGE: MEDICATIONS

> "Over here it [Morphine] is just dispensed like nothing. Yeah, I don't know if that is right or what, but back home we were able to handle pain without large doses of narcotic. And that leads to a lot of abuse over here um compared to back home where people, we don't see a lot of people addicted to Morphine or something like that. Yes I think it's a cultural thing, Asians have more pain tolerance, I'm not saying this in a bad way but I think it's a fact that they have a higher tolerance for pain. Over here, like pain is subjective, if they say they are not getting relief from the medication they are being given well you have to address that. Umm if stronger analgesics address the pain for them then I guess we just have to give it to them. [Christopher, RN]
>
> [6.16] DIFFERENT APPROACH: PAIN MGT

Consistent with the coding process described by Saldaña (2013), the text was read and reread. Important concepts were highlighted. Researcher notes and codes were applied to the margins. On subsequent readings, codes became more refined. Some codes were subsumed

by other codes, some were renamed and some dropped entirely. This process was time consuming but essential. As Saldaña (2013) notes:

> Coding *well* requires that you reflect deeply on the meanings of each and every datum. Coding *well* requires that you read and reread and reread yet again as you code, recode and recode yet again. Coding *well* leads to total immersion with your data corpus with the outcome being exponential and intimate familiarity with its details, subtleties, and nuances" (p. 39)

The greatest challenge encountered during the coding process was to ensure the codes accurately reflected the intent and meaning of participants. As the researcher had both conducted the interviews and transcribed the transcripts, when analyzing the data not just the words but also the intonation participants' placed on their words could be interpreted. For a beginning researcher this was incredibly valuable. For example, while reading the text the researcher could "*hear"* the emphasis a participant placed on a particular passage and this assisted in the identification of salient topics and text worthy of in-depth analysis.

Once the descriptive codes had been applied to the data, the final stage in the coding process was to group similarly coded data into broader categories. During this stage of the analysis, coded text were logically linked and recurring patterns identified (Saldaña, 2013). For example, on rereading the data on post-employment challenges, conceptually similar descriptive codes were merged and categories were formed. An illustration of this process is provided in Table 3.

Table 3. Post-employment challenges data categorization

Descriptive Code	Category
6.6 Idioms	Sociocultural
6.7 Communication with patients	Communication
6.8 Communication with families	
6.9 Communication with IDT	
6.10 Assertiveness	
6.11 Delegation	

One of the decisions made during this stage of the analysis was whether to use one of the computer software packages for qualitative analysis, a simple word processing program,

conduct manual coding from printed documents, or use a combination of computer software and a manual approach to coding. Qualitative software packages allow the researcher to enter raw data into the program, apply codes, and manipulate data; however, they cannot conduct the actual data analysis. The researcher still needs to read, re-read, and be immersed in the data (Ward et al., 2013). Early in the qualitative data analysis process, the researcher discovered that while there were tremendous benefits to being able to manipulate the data using computer software, a paper based format was preferred (by the researcher) when reviewing the transcripts and applying codes. Thus, a combination of computer software and a manual approach was utilized. A decision was made to use Microsoft Word over other qualitative software packages as the researcher had a great deal of comfort with the program and the software could support the manipulation of data to the level required.

Stage four: Charting. During the fourth stage of Framework Analysis data are reduced and summarized into charts that are either organized by case (participant) or by theme (Ritchie & Spencer, 1994). The charting process allows for easy retrieval of data and adds transparency to the data analysis process by clearly displaying the data upon which themes are constructed (Dixon-Woods, 2011; Furber, 2010). Charts are devised with headings and subheadings; when a thematic approach is adopted a chart is developed for each theme and entries are made for multiple respondents on each chart. One of the key features however, is that for each thematic chart the cases are always presented in the same sequence to allow the researcher to easily review themes across the whole data set while ensuring the views of each participant remain connected to other parts of their account (Gale et al., 2013; Ritchie & Spencer, 1994). This ensures that the context of an individual's view is not lost in the analysis (Gale et al., 2013).

One of the challenges for a beginning researcher is knowing how much data to include in each chart. It is important to include enough data to make sense of the entry without including entire quotations (Ward et al., 2013). To address this concern, key words were included in the chart along with a reference to the page number (provided by page numbering function in Word). In addition, an asterisk was attached to excerpts of text that were particularly meaningful and could provide illustrative examples in the final write up (Ward et al., 2013). An illustration of the thematic chart that was developed for the theme 'post-employment challenges' is provided in Appendix L.

Stage five: Mapping and interpretation. Once all the data has been coded and charted according to the main themes, the researcher begins to refine the themes and sub-themes and

interpret the data as a whole (Ritchie & Spencer, 1994). It is at this stage that the researcher considers the true objective of the qualitative data analysis and makes sure the research questions are adequately addressed (Ritchie & Spencer, 1994). In qualitative descriptive research the aim is to provide detailed descriptions of concepts in everyday language and to offer a detailed account of a phenomena and the meaning participants attribute to it (Sandelowski, 2010). To accomplish this the researcher reviewed the charts, compared and contrasted accounts, and searched for patterns and connections (Ritchie & Spencer, 1994). To ensure the refined categories and sub-themes were true to the participants' descriptions, the researcher continuously referred to the original transcripts and compared meaning across interviews (Smith & Firth, 2011). As Ritchie and Spencer (1994) emphasize, it is important that this process of interpretation involves more than simply aggregating data, but also requires "weighing up the salience and dynamics of issues, and searching for a structure rather than a multiplicity of evidence" (p. 186). An example table, showing the progression from the initial codes to categories to sub-themes, is provided in Appendix M.

Integration of quantitative and qualitative findings. Once the qualitative and quantitative data analyses were complete, the final stage in the data analysis process involved the integration of qualitative and quantitative findings. At this point, the quantitative findings were reviewed and interpreted alongside the corresponding qualitative results. The simultaneous interpretation of both data sets was undertaken for each of the research objectives; this integration is evident in the results narrative as the quantitative findings have been presented within the description of the qualitative results (Dahlberg et al., 2010). According to Morse (2015), it is important that the integration of qualitative and quantitative findings is evident in the results write up as "this integration is the purpose and strength of a mixed methods design" (p. 214).

One of the principal reasons a mixed methods approach was utilized for this study was to provide *Complementarity*, in essence to enrich and enhance quantitative findings with descriptive qualitative text (Greene et al., 1989/2008). The interpretation of quantitative data alongside the qualitative results during the final analysis was instrumental in achieving this purpose. For example, in the analysis of the data pertaining to research objective four *(explore the factors that influenced the Filipino nurse's decision to work as a Registered Nurse (RN), Licensed Practical Nurse (LPN) or Unregulated Health Worker (URHW) in Western Canada),* the quantitative data revealed that 100% of participants initially intended to work as a RN upon arrival to Canada. The corresponding qualitative data were then analyzed in conjunction with this numerical data. The interpretation of both data sets together provided a much more

complete description than either data set could provide on its own. While the statistical data provided insight into the participants' intentions to work as RNs, the qualitative data provided a detailed description of the reasons the LPN and URHW participants were not currently working in this role.

Similarly, the interpretation of both sets of data on post-employment supports yielded more complete findings than the interpretation of the results from either data set alone. For instance, a total of 90.2% of RN and LPN respondents to the online survey ranked hospital orientation as "very" or "quite helpful" in assisting with their integration into the nursing workforce. Interpreting this result in isolation, one could reasonably conclude that current employment orientation programs were adequate. However, during the telephone interviews, participants were asked to describe the orientation they had received from their employers when first employed as a nurse in Canada. The answers amongst participants varied considerably. While some IENs described a comprehensive orientation offered over several months, others indicated that only a few days of orientation had been provided. Although participants agreed that the orientation they received had been helpful, the length and quality of the orientations were not always considered adequate. The qualitative data expanded on the specific aspects of orientation that were considered helpful as well as areas that required improvement. Thus, the qualitative data provided further insight and the findings, when interpreted alongside the quantitative results, provide a more complete understanding of hospital orientation as an employment support.

A third illustration is provided in the data collected on the perceived influence of race, ethnicity, and/or colour on integration into the nursing workforce. Amongst participants a total of 25% of RNs and 22% of LPNs agreed or strongly agreed with the statement that their race, ethnicity, or colour had an effect on their relations with colleagues. The qualitative data provided illustrations and examples of experiences IENs had encountered with racist attitudes or discriminatory behaviours; thus one result *complemented* the other. In addition to enriching the overall findings, the simultaneous interpretation of both data sets provided context and additional clarification. In this example, if the qualitative data had been interpreted on its own, the prevalence of experiences with racism and discrimination would not have been revealed. In the absence of the quantitative data the reader may have erroneously concluded that these attitudes and behaviours impacted the majority or all participants. Knowing the prevalence amongst participants added important data, and provided a more complete description of this phenomenon amongst the study participants.

Chapter Four: Findings

The findings from both quantitative and qualitative data have been organized according to the research objectives and are presented in nine sections. The sections are:

- The demographic characteristics of the sample
- Workforce profile prior to migration to Canada
- The migration decision
- Entering the regulated nursing workforce in Canada: Pre-licensure challenges
- The decision to work as a LPN, RN, or URHW
- Entering the regulated nursing workforce in Canada: Pre-licensure supports
- The current workforce profile of RN and LPN participants
- Integrating into the regulated nursing workforce in Canada: Post-employment challenges
- Integrating into the regulated nursing workforce in Canada: Employment supports

Note: Direct quotations from participants are included throughout the chapter and a key to the abbreviations used by participants has been provided in Appendix N. To ensure anonymity, when reporting the qualitative findings initials have been randomly assigned to each of the survey participants and fictitious names have been used when quoting the comments of the telephone and face to face interview participants.

The Sample

A total of 172 participants (84 RNs and 88 LPNs) from Alberta, Saskatchewan, and Manitoba completed the online survey. A sub-sample of 22 survey respondents participated in follow-up telephone interviews. Of the 22 participants, 12 were LPNs and 10 were RNs, with participants from each of the three Prairie Provinces. In addition to the 172 RN and LPN participants, a total of 10 IENs from the Philippines who were currently working as URHWs participated in face to face or telephone interviews. The URHW participants were from Alberta (n=2) and Manitoba (n=8); there were no URHW participants from Saskatchewan.

Section One: Demographic Characteristics of Sample

Research Objective: Describe the demographic characteristics of nurses who have migrated from the Philippines to Canada between 2008 and 2013.

The majority (77.5%) of IENs who participated in the study were female. The largest percentage (41.8%) were between the ages of 20 to 30, with an additional 40.7% between the ages of 31-40. A small percentage (4.4%) were over the age of 50 (see Table 4). A Chi-square test for independence indicated no significant difference between the ages of LPNs and RNs, χ^2 (3, n=172) = 4.015, p = .26, or the number of men or women in each group, χ^2 (1, n=172) = .12, p=.73.

Table 4. Sample Characteristics – Age & Sex

Frequency (%)	RNs	LPNs	URHWs	Total
Age				
20 – 30	36 (42.9)	33 (37.5)	7 (70)	76 (41.8)
31 – 40	32 (38.1)	40 (45.5)	2 (20)	74 (40.7)
41 – 49	14 (16.7)	9 (10.2)	1 (10)	24 (13.2)
50 or older	2 (2.4)	6 (6.8)	-	8 (4.4)
Sex				
Male	21 (25)	19 (21.6)	1 (10)	41 (22.5)
Female	63 (75)	69 (78.4)	9 (90)	141 (77.5)

A total of 64.3% of participants were married or with a partner. Of these, the majority (94.9%) indicated that their spouse or partner were living with them in Canada. Six participants indicated that their spouse or partner were currently living in the Philippines (see Table 5). A Chi-square test for independence indicated no significant difference between the marital status of LPNs and RNs, χ^2 (1, n=167) = .36, p = .55.

Table 5. Marital Status

Frequency (%)	RNs	LPNs	URHWs	Total
Married or with a Partner				
Yes	53 (63.1)	60 (68.2)	4 (40)	117 (64.3)
No	28 (33.3)	26 (29.5)	6 (60)	60 (33)
Prefer not to say	3 (3.6)	2 (2.3)	-	5 (2.7)
Location of Partner if applicable				
In Canada	49	58	4	111
In the Philippines	4	2	-	6

Just over one half (52.7%) of the study participants indicated that they had children. Of these, 37.5% (36/96) reported that their youngest child was of pre-school age, and 40.6% (39/96) stated that their youngest child was of school age. The majority (89.6%) of participants with children reported that their children were currently living in Canada. Five of the participants who reported having children indicated that their children were living in the Philippines and an additional four reported that their children were living in another country (see Table 6). Of the nine IENs whose children were living apart from them, five participants noted that their youngest child was "older" and four participants reported that their youngest child was "school age". In addition, four of these nine participants indicated that their spouses or partners were currently living in the Philippines. The results of A Chi-square test for independence indicated that there was no statistically significant difference between the number of LPNs versus RNs who had children, χ^2 (1, n=169) = 3.0, p = .08. Likewise, the age of the children was not significantly different between the LPN and RN participants, χ^2 (1, n=80) = .22. p=.64.

Table 6. Parental Status

Frequency (%)	RNs	LPNs	URHWs	Total
Children				
Yes	38 (45.2)	53 (58.2)	5 (50)	96 (52.7)
No	43 (51.2)	35 (41.8)	5 (50)	85 (46.7)
Prefer not to say	3 (3.6)	0	-	3 (1.6)
Age of Youngest Child				
Pre-School	13	21	2	
School Age	16	20	3	
Older	4	6	-	
Md	5	6	-	
Location of Children if applicable				
In Canada	32	49	5	
In the Philippines79.	3	2	-	
Other (Hong Kong/UK)	2	2	-	
Md	1	-		

The highest percentage (33%) of participants arrived in Canada in 2008. An additional 31.9% arrived in 2009, 7.5% in 2010 and a further 20.9% arrived in 2011. Only a small percentage of participants arrived in Canada in 2012 (6%) and 2013 (0.5%) (See figure 8).

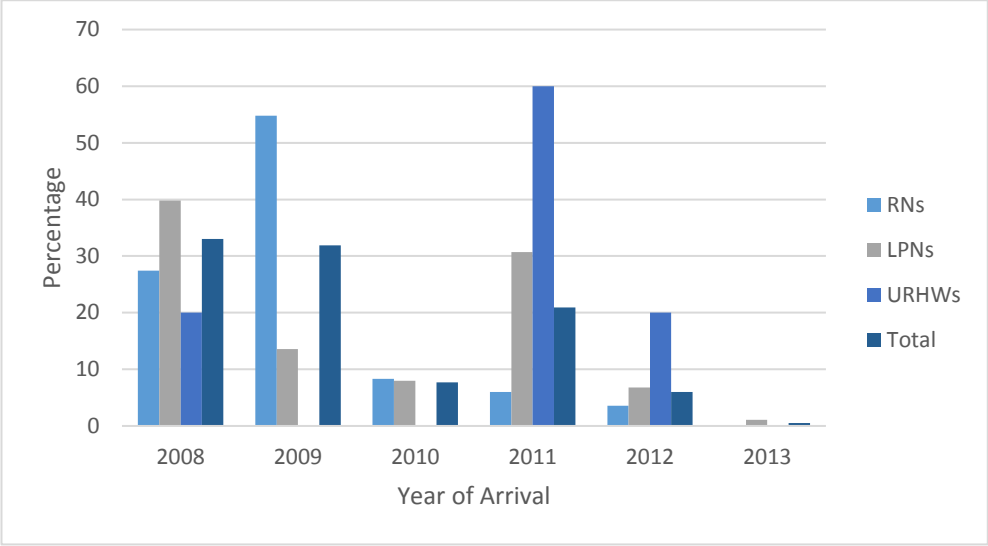

Figure 8. Year of arrival in Canada.

As Figure 9 shows, the percentage of participants living in Alberta and Manitoba were relatively similar; however, the ratio of RN, LPN, and URHW participants in each province varied considerably. A total of 31% of RNs, 67% of LPNs, and 20% of URHWs were currently residing in Alberta, while 65.5% of RNs, 25% of LPNs, and 80% of URHWs were currently living in Manitoba. Only 5.5% of participants, 3.6% of RNs, and 8% of LPNs were from Saskatchewan.

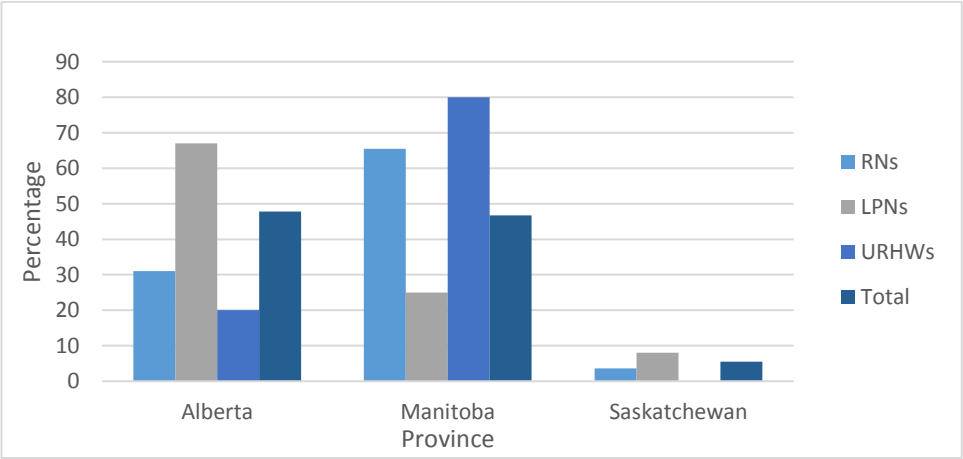

Figure 9. Province currently residing.

A sub-sample of 12 LPN and 10 RN survey respondents participated in telephone interviews. The sub-sample characteristics are presented in Table 7. The characteristics of the

sub-sample consisted of participants from all three Prairie Provinces, all age categories with the exception of 50 and older, both sexes, and all years of arrival in Canada.

Table 7. Sub-Sample Characteristics

Descriptor	**RNs**	**LPNs**
Year of Arrival in Canada		
2008	3 (30%)	2 (16.7%)
2009	3 (30%)	-
2010	3 (30%)	3 (25%)
2011	-	4 (33.3%)
2012	1 (10%)	2 (16.7%)
2013	-	1 (8.3%)
Province Currently Registered		
Alberta	2 (20%)	7 (58.3%)
Saskatchewan	1 (10%)	3 (25%)
Manitoba	7 (70%)	2 (16.7%)
Age		
20 – 30	2 (20%)	6 (50%)
31-40	5 (50%)	4 (33.3%)
41 – 49	3 (3%)	2 (16.7%)
50 or older	-	-
Sex		
Male	3 (30%)	4 (33.3%)
Female	7 (7%)	8 (66.7%)
	n=10	**n=12**

Section Two: Workforce Profile Prior to Migration to Canada

Research Objective: Describe the past workforce profile of nurses who have migrated from the Philippines to Canada between 2008 and 2013.

Education. The IENs who participated in this study possessed a substantial amount of post-secondary education. A total of 181 participants responded to the question regarding post-secondary education in the Philippines. Of these, 100% had completed a Baccalaureate degree in Nursing. A further 21% of participants had completed additional post-secondary education: 9% had earned a Baccalaureate degree in another discipline, 7% had obtained a Master's degree, 3% were Doctors of Medicine or Dental Medicine, and 2% had completed additional course work toward a second degree (see Table 8).

Table 8. Post-Secondary Education Obtained in the Philippines

	RN	LPN*	URHW	Total*
Frequency (%)				
Baccalaureate Degree -Nursing	84 (100)	87 (100)	10 (100)	181 (100)
Baccalaureate Degree – Other Discipline	9 (11)	7 (8)	1 (10)	17 (9)
Master's Degree	3 (4)	9 (10)	1 (10)	13 (7)
Doctor of Medicine	2 (2)	1 (1)	-	3 (1.5)
Doctor of Dental Medicine	1 (1)	1 (1)	1 (10)	3 (1.5)
Other	1 (1)	1 (1)	2 (20)	4 (2)
Md		1		1

**valid percentage: LPN (n=87); **Total (n=181)*

Almost three quarters (73%) of IENs qualified as Registered Nurses in the Philippines in the year 2001 or later. A further 23% qualified between the time periods of 1991-2000. The remaining 4% of participants qualified prior to the year 1991 (see Table 9).

Table 9. Year of Qualification as a Registered Nurse in the Philippines

	RN*	LPN	URHW	Total*
Frequency (%)				
1976-1980	1 (1)	3 (3)	-	4 (2)
1981-1985	1 (1)	-	-	1 (0.5)
1986-1990	1 (1)	2 (2)	-	3 (1.5)
1991-1995	18 (21)	11 (13)	1 (10)	30 (17)
1996-2000	3 (4)	7 (8)	-	10 (6)
2001-2005	27 (33)	40 (46)	2 (20)	69 (38)
2006-2010	32 (39)	25 (28)	7 (70)	64 (35)
md	1			1

**Valid Percentage: RN (n = 83): Total (n=181)*

Experience working as a registered nurse prior to migration to Canada. The majority (89.5%) of IEN participants had paid nursing experience prior to migrating to Canada. A total of 69% of the IENs had experience working as a Registered Nurse in the Philippines, 5% had experience working as a Registered Nurse in another country, and 15.5% had experience working as a RN in both the Philippines and another country. A further 6.1% of participants possessed only volunteer nursing experience and 4.4% of participants had no experience working as a RN before migration to Canada (see Table 10). The results of a Chi-square test for independence (with Continuity Correction) showed no statistically significant difference between the paid work experience of RNs as compared to LPNs, χ^2 (1, n=171) = .80, p=.37, and no significant association between the paid work experience in another country prior to migration to Canada between RNs and LPNs, χ^2 (1, n=171) = 3.5, p=.06.

Table 10. Type of Work Experience – Prior to Migration to Canada

Frequency (%)	**RNs***	**LPNs**	**URHWs**
Paid Nursing Experience			
Philippines-Only	50 (60.2)	67 (76.1)	8 (80)
Another Country – Only	6 (7.2)	3 (3.4)	-
Philippines & Another Country	17 (20.5)	11 (12.5)	-
Volunteer Nursing Experience- Only	6 (7.2)	3 (3.4)	2 (20)
No Nursing Experience	4 (4.8)	4 (4.6)	-
Md	1	-	-
	84	88	10

A total of 68 IENs (37%) worked as a volunteer nurse in the Philippines. The majority of these IENs (84%) worked in both volunteer and paid nursing positions before moving to Canada. The remaining 16% only worked in a volunteer nursing position. The majority (90%) of IENs who worked as a volunteer nurse did so for a period of one year or less.

The majority of IENs with paid nursing experience reported that they had worked between 0-5 years as a RN prior to arrival in Canada. Of those with paid nursing experience, almost two thirds (63.6%) had worked between 0-5 years as a RN in the Philippines or another country. An additional 6.1% of participants had worked between 0-5 years in both the Philippines and another country. A total of 30.2% of RNs and LPNs reported more than 5 years of experience as a RN in the Philippines or another country or in both the Philippines and another country, prior to moving to Canada (see Table 11).

Table 11. Length of Work Experience – Prior to Migration to Canada

Frequency	**RNs**	**LPNs**	**URHWs**
Paid Nursing Experience – Philippines Only			
0- 5 years	45	47	8
>5 years	5	20	-
Paid Nursing Experience – Another Country Only			
0-5 years	2	1	-
>5 years	4	2	-
Paid Nursing Experience – The Philippines & Another Country			
0-5 years in both the Philippines & another country	5	5	-
>5 years in the Philippines &/or another country	12	6	-
Md	1	-	-
Total	**74**	**81**	**8**

Primary practice setting prior to migration to Canada. The majority (81.3%) of participants practiced as a RN in an acute care setting prior to arrival in Canada (see Table 12). A total of 77% of RNs, 74% of LPNs, and 80% of URHWs identified a Staff Nurse position as their primary role prior to arrival in Canada. Notably, a total of 11% of participants (17% LPNs and 6% RNs) listed their primary position as a Nurse Educator or Clinical Instructor (Table 13).

Table 12. Primary Practice Setting as a RN Prior to Migration to Canada

Frequency (%)	**RN**	**LPN***	**URHW**	**Total**
Acute Care	69 (82.1)	71 (80.8)	8 (80)	148 (81.3)
Long Term Care	2 (2.3)	1 (1.1)	-	3 (1.6)
Public/Community/School Health	4 (4.8)	3 (3.4)	-	7 (3.8)
University/College	1 (1.1)	6 (6.8)	-	7 (3.8)
Out-Patient Clinic	2 (2.3)	3 (3.4)	1 (10)	6 (3.2)
Occupational Health	2 (2.3)	-	-	2 (1.0)
Insurance Company	-	-	1 (10)	1 (.05)
No Nursing Experience	4(4.8)	4 (4.5)	-	8 (4.4)
	n=84	n=88	n=10	n=182

Note. Both Paid and Volunteer Nursing Experience included.

Table 13. Primary Nursing Position Prior to Migration to Canada

Frequency (%)	**RN**	**LPN**	**URHW**	**Total**
Volunteer Nurse	6 (7.1)	3 (3.4)	2 (20)	11 (6.0)
Staff Nurse	65 (77.4)	65 (73.8)	8 (80)	138 (75.8)
Nurse Manager	3 (3.6)	1 (1.1)		4 (2.2)
Nurse Educator/Clinical Instructor	5 (6.0)	15 (17.1)		20 (10.9)
Clinical Nurse Specialist	1 (1.1)	-		1 (.05)
Did not work as a Nurse	4 (4.8)	4 (4.5)		8 (4.4)
	n=84	n=88	n=10	n=182

Section Three: Migration to Canada

Research Objective: Identify the factors that influenced the Philippine nurse's decision to migrate to Canada.

Migration decision. Participants completing the online survey were asked to identify the factor that most influenced their decision to migrate to Canada. Almost one-half (48.4%) of all respondents indicated that their primary reason for migration was financial. Better job opportunities, higher salaries, and the ability to assist family members residing in the Philippines were cited as important factors influencing their decision to migrate (see Table 14). A total of 21.9% of respondents identified social factors as the primary reason for migration. Family reunification and the opportunity to provide a better future for their children were the main social factors identified. Professional factors were identified by 13.2% of participants as the primary reason for migration. Qualitative responses cited opportunities for career advancement and professional growth as important. Finally, personal reasons, to travel or experience a different way of living, were identified by 12.1% of participants as the primary reason for migration.

For a few survey participants, a combination of factors influenced their migration decision. For example, one participant indicated that her primary reason for migration was social, but she commented that she moved to Canada "for the future of my children and we have a good opportunity to earn more" [B.C., LPN], revealing that financial factors were also influential. Another participant indicated that her primary reason for migration was professional, but she had moved "[to] explore my career and professional growth while helping my family in the Philippines" [I.J., RN], showing that both professional and financial factors were important. Similarly, five of the participants who chose the "Other" category for the question on the online survey indicated that their decision to migrate was influenced by several factors. A combination of professional and financial reasons, professional and social reasons, or "all of the above" were identified as influencing factors. Thus, for these participants, a combination of social, financial, professional, and/or personal factors influenced their decision to migrate.

Table 14. Primary Reason for Migration to Canada

Reason for Migration	RN	LPN	URHW	Total
	Freq.(%)	Freq.(%)	Freq.(%)	Freq.(%)
Financial (better wages; to be able to send money back to the Philippines)	40 (47.6)	45 (51.1)	3 (30)	88 (48.4)
Social (to join family and friends; to enable children to grow up in Canada)	19 (22.6)	16 (18.2)	5 (50)	40 (21.9)
Professional (to gain professional development; to work as a nurse)	11 (13.1)	12 (13.6)	1 (10)	24 (13.2)
Personal (to travel; experience a different way of living)	12 (14.3)	10 (11.4)	0 (0)	22 (12.1)
Other	2 (2.4)	5 (5.7)	1 (10)	8 (4.4)
	n=84	n=88	n=10	n=182

Why Canada and why the Prairie Provinces? The factors that motivated IENs from the Philippines to move to Canada were further explored during the qualitative interviews with RNs and LPNs. Specifically, participants were asked to discuss their reasons for choosing Canada over other countries, as well as their reasons for choosing to move to the Prairie Provinces. Participants identified four main reasons: the presence of family in Canada, the demand for nurses in the Prairie Provinces, ease of migration, and the opportunity for a better life in Canada.

The presence of family in Canada. The presence of family in Canada was cited by a number of participants as their primary reason for choosing to migrate to Canada. Family sponsorship allowed participants to enter Canada as permanent residents through the

immigration category "Family Class". Some participants were sponsored by members of their immediate family. Pearl was sponsored by her sister:

> "I moved here to Canada because my older sister sponsored me. She's been here for 18 years already and then in 2009, when the Saskatchewan nominee program opened, she was able to sponsor a family member going here. And umm, I was one of the sisters who was sponsored by her. [Pearl, LPN]

Ramon was sponsored by his wife:

> "I moved here in Canada because my wife was hired in the Philippines by the government to work as a nurse. I think the Manitoba government went to the Philippines to hire some Filipino nurses and she got, umm, she passed the exams and the interviews and she migrated here in 2009 and I followed her here a year after [Ramon, LPN].

Other participants were sponsored by members of their extended family, some of whom had lived in Canada for many years and had sponsored multiple family members from the Philippines. Christina commented:

> "We came to Canada under the Saskatchewan immigrant nominee program. We were nominated by my sister in law. She was here 10-11 years ago and based herself here. So she invited her brothers and sisters and their families and one of them was my husband and we were the last ones to come, [Christina, LPN]

Likewise, Grace explained:

> "My husband was coming here to Canada because his family, on his mother's side, is here in Canada; in Winnipeg.... Canada was the only country we considered. They [husband's family] were here back in the 70s. One of his uncles, who was here first came as a worker and then started getting more of his brothers and then cousins and uncles and then more and more of them here. [Grace, RN]

For these participants, Canada was their first choice of countries to migrate to. They chose to move to one of the Prairie Provinces because that was where their family members resided.

> "Actually we were under the family sponsorship so we don't have any other choices like in mind as a country. It is the only country we were qualified to go as a family – so that is why we're here. My father's sister is here so it is basically a family sponsorship. [Nicole, LPN]

It is interesting to note that three participants who entered Canada as Temporary Foreign Workers or through the Skilled Worker Immigration Class (not through family sponsorship)

also cited family as a primary reason for choosing to move to Canada. Participants expressed that the presence of family in Canada would ease their transition to a new country. One participant commented, "I decided to come to Canada because my sister was already here. So it was a lot easier for me than moving to the States" [Anna, RN]. Another participant chose to move to Canada to be close to her sister. As a single mother of three children, she hoped that her sister would be able to provide her with support as she adjusted to life in Canada. Unfortunately, on moving to Alberta she realized that her sister, who lived in Ontario, was over 3000 kilometres away:

> "I had my sister here. In Ontario, she migrated to Canada 4-5 years ahead of me..... I got here in Alberta – it was only me – it was so lonely – so alone – my sister, she would understand – it's hard, my three kids, and me, only me living in another country. [Maria, LPN]

The demand for nurses in the Prairie Provinces. A number of participants stated that Canada was not their first choice of countries or that Canada was just one of several countries being considered for migration. The demand for nurses in Canada and the subsequent government recruitments in 2008 resulted in a number of nurses choosing to move to Canada because they received offers of employment in one of the Prairie Provinces. Jeffrey remarked:

> When I was in the Philippines I was working in the ICU in one of the biggest hospitals in the Philippines and I have an application in Vermont in the US. But since they have a recession I've been waiting for a couple of years for the visa to be released but unfortunately I didn't get it. So yeah, I didn't know about Canada, about the opening for nurses before, so I just saw it in the newspaper – I was actually checking the paper and saw Canada needs nurses so I just applied and I also applied at the same time to the UAE and at the same time I applied at a cruise ship. Anyway for Canada, after two days they called me for the final interview and it was actually the Edmonton region - they went to the Philippines and they recruited hundreds of nurses and yeah I had my final interview and after 1 hour I got my final letter to work in the University of Alberta hospital as an LPN. [Jeffrey, LPN]

And Joan explained:

> Umm actually I had my first choice as New Zealand before but then it was Canada who came in first, like you know they were hiring nurses from the Philippines, a friend who was coming, who was also applying to Canada so we went together to the agency and we got lucky to be approved as LPNs. [Joan, LPN]

Finally, Sarah commented that it was the opportunity for employment that made her choose to migrate to one of the Prairie Provinces over other parts of Canada:

> At first we want to go to Toronto because that's where my husband's relatives are but then our agency, someone told us if we're going to Toronto, there will be no jobs for us there so she advised us to go to Alberta, anywhere in Alberta or Saskatchewan. But um so I contacted my aunt, she has a friend here in Alberta and then she offered to help us here in Alberta and that's why we're here. [Sarah, LPN]

Ease of migration. To address the demand for nurses in Canada, nursing was designated a priority occupation in the Federal Skilled Worker Immigration Class. As a result, nurses were awarded additional points on their immigration applications making it easier to have applications for permanent residency approved. For several participants, the speed of approval of their applications for permanent residency was the primary reason they chose to move to Canada. For these participants, Canada was not their first choice of countries. Participants indicated that their initial plans were to move to the United States (U.S.) but delays in processing U.S. visas and the lack of hiring of nurses in the U.S. made them look towards Canada:

> Well honestly I was thinking the states before but then at that time the states, the US, are no longer hiring nurses– actually it was my husband he introduced me to applying to Canada – so we applied together, fortunately we got it approved so that's why we're here. We applied as Federal Skilled Workers – as immigrants. [Sarah, LPN]

Similarly, Isaak described:

> OK umm well originally it was like the US however there was the recession of 2009 and all the applications from the Philippines were pending and some of them were held back by 3 years now so I didn't actually have any country in particular and I even considering Australia, New Zealand…. I heard about the recruitment – the SRNA coming to the Philippines when they recruited Filipino nurses umm but there was no word about it but when I looked into CIC website the application for nurses under federal skilled workers was still open and it was fast tracked around 8-12 months. [Researcher: So you came as a permanent resident?] Yeah. [Isaak, LPN]

Finally, Edward remarked:

> Ok first thing Canada was never my first choice. Whenever I was in the Philippines I was applying for a visa screen in the US and I had submitted all the documents the US government needs to process the visa – only meant to say they are still pending and it would take up a lot of time. A friend of mine invited me to apply to Canada – so that is what I did. Umm I applied through Federal Skilled Worker. I applied in 2010 just by chance I just want to try it out…. So I just tried to broaden my opportunities for myself and my family. So that is how it happened. [Edward, LPN]

Opportunity for a better life in Canada. The presence of family residing in Canada, the demand for nurses in the Prairie Provinces, and the ease of migration were the main reasons cited for choosing to move to Canada; however, the opportunity to live a better life in Canada was also identified as a key reason for choosing to move to Canada. As Maria remarked:

> Canada became an option - raising my children where they would be given more chances and opportunities. Canada will provide best education. It is the place I had envisioned to grow me as a person, a citizen, a single mother of three and a country to my children which will enhance their innate talent and intellect. [Maria, LPN]

Vince and Christopher chose to move to Canada as they considered it a progressive and safe country, free of corruption that could provide good benefits and opportunities for new immigrants. Vince remarked, "I chose Canada because it is a very progressive country and they provide good benefits to the people" [Vince, LPN]. And Christopher explained:

> I received feedback that Canada is a good place for opportunity for immigrants who are looking for a place for career growth, fair play - without corruption from government and there is system like in the Philippines if you know someone you can get hired so it is kind of like an opportunity for fair play, career growth and a good life. [Christopher, RN]

Migration pathway. Although the majority of participants (69%) reported that prior to migration they had worked in only the Philippines as a nurse, a total of 39 (21.4%) participants had worked as a nurse in another country before moving to Canada. Although participants were not specifically asked which country they worked in prior to moving to Canada, several revealed through their comments that they had previously worked in the Middle East, Cambodia, or the United Kingdom (U.K.).

The reasons for migrating to Canada from another country (step migration) were further explored in the qualitative interviews with RNs and LPNs. A total of four of the 22 interview participants indicated that they had worked in another country before moving to Canada. Amongst these four participants responses varied. One participant chose to move to a Canada (although the US had been her first choice) instead of returning to the Middle East because she felt that, as a woman, Canada would afford her more independence. She stated, "I will have some independence in here, can buy my own property, can move around safely, things like that and I like cold weather, that's why, so that's the only thing, I just move here" [Bea, RN]. Another participant, who had also previously worked in the Middle East, was attracted by the possibility of becoming a permanent resident and living with his family in Canada. He explained, "I used to work in the Middle East, I worked there for about 3 years and I went

back home and there was an opening for Manitoba and I applied and the thing that got me interested in that is that I would be able to become a resident of Canada and bring my family over" [Joseph, RN]. A third participant, a long-time resident of the UK, described how the recent demand for nurses in Canada opened up an opportunity for additional travel and adventure:

> In the fall 2007 there were flyers in central London and they were saying that they were hiring in Canada and so on and I thought maybe it was just one of those bogus recruitments but I thought there is no harm in inquiring - so one of my friends – I showed her – and we went into the hotel and I thought we would just inquire and they were already interviewing like 9 of them on the panel -so anyways- I was quite elated at the end of the day, it was so productive, like this is like going to another place and you know how I love to travelling and maybe its high time I go to North America because I've been most of the places in uh in Europe. [Michelle, RN]

All three of these participants indicated that they planned to stay in Canada and had no plans to migrate again. By contrast, Jennifer, who lived and worked in the U.K. for 12 years, chose to move to Canada to join family. She stated, "I worked in the Philippines for 5 years and then went to the U.K. and worked as a RN for 12 years and due to no family in the U.K., my husband, his whole family is here in Manitoba so we decided to migrate here in Manitoba" [Jennifer, RN]. However, the "pull" of family in Canada may not be enough for Jennifer to stay in Canada. Although she has obtained a license as an RN, her husband, also a nurse, has encountered multiple challenges with the registration process. When asked if she plans to stay, she laughs and states, "We're still undecided. Undecided in the sense that maybe I think it's still a struggle, for me maybe just because I'm the one who's working because my husband still has to do all his stuff – so we're just keeping our options open" [Jennifer, RN].

Canada: A step toward the U.S. Two IENs who participated in the qualitative interviews initially moved to Canada on a temporary basis while waiting for their U.S. visa. Victoria initially planned to migrate, with her family, to the U.S. from Canada. Just one month after arrival to Canada, she was called for an interview by U.S. immigration officials; however, upon consideration, both Victoria and her husband decided to stay in Canada and chose not move to the U.S. as originally planned:

> We were already booked to be interviewed by the US immigration for our visa for the US but then we declined it because we were already in Canada and we have seen the differences. We weighed things, the health care programs and all those things are a lot better in Canada than in the US, the economy is a lot better here than in the US and it's more family based, family oriented. That's what I see, people in Canada are more

> family oriented. We actually weighed everything so finally we decided just to stay in Canada and not go to the US. [Victoria, LPN]

While Victoria made the decision to remain in Canada, Edward continues to pursue immigration to the U.S. When he was living in the Philippines, he completed the requirements for registration as a RN in the U.S. While waiting for U.S. immigration approval, he received permanent resident status in Canada and moved to Alberta in 2013. He is currently licensed as a LPN and has applied for licensure as a RN. When asked if he planned to stay in Canada, he responded:

> We are keeping it open only because unlike here in Canada– I am already an RN there - where here I am still in the process of becoming an RN - I am blessed to have the LPN but my career still is an RN, so which ever brings me – I want to have a second option – but for now I think I will have the position of staying in Canada – considering what we have right now - so we are just making the most of it. [Edward, LPN]

Faced with the prospect of working as an LPN in Canada or a RN in the U.S., Edward indicated that he would choose to work as a RN in the U.S.; however, if he is able to obtain a license as a RN in Canada before his U.S. visa has been approved, he indicated he would likely stay.

Interestingly, one online survey respondent, a RN who migrated to Manitoba in 2009, [living close to the U.S. border] indicated that she is currently working in both Canada and the U.S. "I worked full time for my current employer for a year and 6 months and turned casual. I feel that that is enough to hone my clinical skills..... I am likewise working now as an internationally educated nurse in the US" [G.C., RN]. The participant did not indicate if she plans to continue to work in both countries, or move to the U.S. in the future.

Immigration status in Canada. Almost one half (47.2%) of all participants entered Canada as Temporary Foreign Workers (TFWs). An additional 52.2% entered Canada as permanent residents: 41.1% entered through the economic class as Federal Skilled Workers, 8.9% entered through the family class, and 2.2% did not specify the permanent resident immigration classification they were assigned upon entry to Canada (see Table 15). Although the online survey or interview questions did not specifically ask participants who entered as TFWs if their permits were issued to work as RNs, a number of participants self-disclosed that their entry visas were issued as URHWs or LPNs. One URHW and six LPNs indicated that they entered Canada as URHWs while eight LPNs and six RNs stated that they entered Canada as LPNs. It is of note that all 21 of these participants initially migrated to Alberta.

Table 15. Immigration Category on Arrival to Canada

	RN	LPN	URHW	Total
	Freq.(%)	Freq.(%)	Freq.(%)	Freq. (%)
Economic Class	28 (34.1)	40 (44.3)	6 (60)	74 (41.1)
Family Class	8 (9.8)	5 (6.8)	3 (30)	18 (8.9)
Temporary Foreign Worker	42 (51.2)	42 (47.7)	1 (10)	85 (47.2)
Spousal Visa	-	1 (1.1)	-	1 (.06)
Other (Permanent Resident – Immigration category not specified.)	4 (4.9)	-	-	4 (2.2)
Md	2	-	-	2
	n=84	**n=88**	**n=10**	**n=182**

The majority (79.7%) of IENs indicated that they were the primary applicants for immigration to Canada. Of the remaining participants, 11.5% identified her/his spouse and 6.6% stated her/his parents had been the primary applicant (see Table 16). All 12 of the IENs who migrated with their parents identified that their current age was between 20 to 30 years.

Table 16. Primary Applicant for Immigration to Canada

	RN	LPN	URHW	Total
	Freq.(%)	Freq.(%)	Freq.(%)	Freq.(%)
IEN	66 (78.6)	73 (83.0)	6 (60)	145 (79.7)
Spouse	10 (11.9)	9 (10.2)	2 (20)	21 (11.5)
Parents	6 (7.1)	4 (4.5)	2 (20)	12 (6.6)
Other*	2 (2.4)	2 (2.3)	-	4 (2.2)
	n=84	**n=88**	**n=10**	**n=182**

Note. *Identified "Other": Did not specify the primary applicant.

Intention to stay in Canada. At the time the survey was conducted, the immigration status of many participants had changed. Only 6% of IENs remained on temporary work permits while 92.9% of participants were permanent residents. Two IENs (1.1%) were Canadian citizens (see Table 17).

Table 17. Current Immigration Status in Canada

	RNs	LPNs	URHWs	Total
Canadian Citizen	1 (1.2)	1 (1.1)	-	2 (1.1)
Temporary work permit	5 (6.0)	5 (5.7)	1 (10)	11 (6.0)
Landed Immigrant/ Permanent Resident	78 (92.9)	82 (93.2)	9 (90)	169 (92.9)
Total	**84**	**88**	**10**	**182**

The majority of IENs who participated in the qualitative interviews indicated that they planned to stay in Canada. Despite experiencing a number of challenges, participants commented that they had no regrets, felt at home, or, simply, that things were better in Canada than in the Philippines. As Michelle expressed:

> People ask why did I move here, I say well London is not a bad place, it is a beautiful place too, you want to explore stuff, it's a very good place and the travel to Europe it's very good. However, if you want a family it is not the best place – this is still the best place -you have the space. An ordinary person can afford a house um and space for a barbeque – if you live in central London you can only have a flat which is what I used to have. A two bedroom flat but the price is very high – so I say count yourself lucky – you have your house, you have the space, you have your basement... I have no regrets moving to Canada. [Michelle, RN]

Likewise Bea remarked, "I think I will stay I'm pretty much comfortable here. I bought my property and everything and I was quite a bit independent and I have established my relationship with my friends so yeah…I'm feeling a little bit like at home in here" [Bea, RN]. And Isaak explained, "My integration wasn't that smooth but I managed and I haven't reached my goal yet but I'm working on it... Well I'm happy to be here it is better than where I was – I always say to myself that back home a nurse in earning $1.50 an hour so I would say I would be better off here." [Isaak, LPN]

Two participants expressed their intention to stay in Canada but cited future plans to move to a different province or community within Canada. Joseph noted:

> I was very thankful that I was able to bring my family and they are happier so I will be staying… my daughters are in their early school so I will move to a city or a place with a University when they are older – I would rather be near them. I don't want them to go on their own. [Joseph, LPN]

And, Christopher commented:

> I have become a permanent resident and you would say I have established roots, I have bought a house here so umm I've worked here for 5 years so basically kind of like a home now. [Researcher: Do you plan to stay in Saskatchewan?] At this point yes in 5 years plan I may be moving to cities with lots of young people my age, British Columbia, Vancouver. BC is a good province for young people. [Christopher, RN]

In total, only three participants expressed uncertainty regarding their future in Canada. The comments of two participants, Edward and Jennifer [cited previously], reflect their indecisiveness. A similar ambivalence was expressed by Pearl:

> I wanted to experience working and living in a different country as well and umm really part of the reason too is for financially for pay here it is also better, much better, than my country and the experience. [Researcher: Do you plan to stay?] umm for now I'm not yet sure – I'm a permanent resident here already I'm not yet sure if I'll apply for my citizenship or if I'll go back to the Philippines. [Pearl, LPN]

Section Four: Entering the regulated nursing workforce in Canada: Pre-Licensure Challenges

Research Objective: Describe the challenges that nurses from the Philippines encountered while entering the Western Canadian nursing workforce.

Challenges encountered during both the RN and LPN licensure process. Participants in all three groups (RNs, LPNs, and URHWs) reported a number of challenges encountered while seeking Licensure as a regulated nurse in Canada. Meeting the financial requirements and obtaining the necessary English language proficiency levels were identified as challenges common to both the RN and LPN licensure processes.

***Meeting financial requirements*.** One of the main challenges IENs encountered throughout the licensure process was financial hardship. Amongst survey participants, 52.4% of RNs and 46.5% of LPNs reported that it was very difficult or difficult to meet the financial requirements (application, exam, and tuition fees) associated with the registration process. A Mann-Whitney U Test was conducted to compare the perceived difficulty meeting the financial requirements associated with registration between RNs and LPNs. There was no significant difference in scores for LPNs (Md=3.00, n=88) and RNs (Md = 2.00, n= 84), U=3462.000, Z=-.757, p=.449. r=0.06 (see Table 18).

Table 18. Perceived Difficulty Meeting Financial Costs Associated with Registration Process – RNs and LPNs

How difficult was it to meet the financial requirements associated with the Registration process in Canada?			
Frequency (%)	RNs	LPNs	Total
Impossible or Very Difficult	10 (11.9)	4 (4.5)	14 (8.1)
Difficult	34 (40.5)	37 (42.0)	71 (41.3)
Neither easy or difficult	22 (26.2)	31 (35.2)	53 (30.8)
Easy	12 (14.3)	10 (11.4)	22 (12.8)
Very Easy or No Problem	6 (7.1)	6 (6.8)	12 (7.0)
Total	**84**	**88**	**172**

Cost of living expenses, such as food, clothing, housing, and transportation, presented an even greater challenge for participants. The majority, 57.2% of RNs and 61.3% of LPNs, indicated that they found it very difficult or difficult to pay for essentials as they worked through the registration process (see Table 19). A Mann-Whitney U Test was conducted to compare the perceived difficulty meeting the financial requirements associated with the cost of living between RNs and LPNs. There was no significant difference in scores for LPNs (Md=2.00, n=87) and RNs (Md = 2.00, n= 84), U=3595.000, Z=-.196, p=.844. r=0.01.

Table 19. Perceived Difficulty Meeting Living Expenses throughout the Registration Process – RNs and LPNs

How difficult was it to meet the financial requirements for yourself/family throughout the Registration process?			
Frequency (%)	RNs	LPNs*	Total*
Impossible or Very Difficult	13 (15.5)	6 (6.9)	19 (11.1)
Difficult	35 (41.7)	48 (55.2)	83 (48.5)
Neither easy or difficult	22 (26.2)	25 (28.7)	47 (27.5)
Easy	9 (10.7)	5 (5.7)	14 (8.2)
Very Easy or No Problem	5 (6.0)	3 (3.4)	8 (47)
Md		1	1
Total	**84**	**88**	**172**

Note. *valid percent LPNs [n=87], Total [n=171]

The financial challenges experienced by IENs were further explored during the telephone interviews. Participants spoke of difficulties meeting the expenses associated with registration. The length of the registration process and the costs associated with bridging education were most frequently cited as factors that contributed to financial hardship. As one RN noted, "to be an RN it's a long process, lots of money, not everyone passed the exam ... Most of the people I know automatically get a course and the course would cost about $1000.00 per course" [Patricia, RN]. Similarly, Analyn, a single mother, described having to delay applying for Registration until she saved enough money: "I just applied in December 2012 because I needed to save the money for the registration first. Because I'm a single mother right now – so that's why it took me sometime. I went to [a language training program], the one March to June 2012. I kind of stopped there. I needed to work" [Analyn, URHW].

For IENs who entered Canada as TFWs, the costs associated with registration were even greater. Riza, an URHW who entered Alberta as a TFW, delayed pursuing either RN or LPN licensure upon learning the cost of tuition for international students. In Riza's words:

> It was very expensive – for somebody who is internationally educated – even applying as an LPN refresher student it was very expensive for me. I went through the LPN assessment and everything and then I found out as an international student I have to pay 2.4 more - 2.4 times more than a Canadian resident for tuition... The main reason I didn't take the courses after the first assessment was financial. That knocked me down really bad. I thought – Oh no! Where am I going to get the money. Too much money – I'm not earning as much money – I'm only earning like minimum wage and my time would be split between studies and work and I was thinking how am I going to be able to do that and survive that – As far as financial – that's the reason. [Riza, URHW]

For many participants the process took over a year to complete, requiring them to resubmit documents to keep their files active. The sense of frustration and financial burden placed on the IEN and their family was clearly expressed by Lilibeth:

> I need to spend money to update my requirements every year. You need to update it every year – so it's like lots of money for us. First financial, and frustration for me – emotionally for me repeating all the requirements..... It's like I want to help my husband. Financially we are not OK. We are living with my mother in law right now because we cannot afford to have our own umm even having an apartment and we have two children right now so I need to help my husband. [Lilibeth, URHW]

The high cost of living in Canada was also noted by several participants. For Maria, a LPN in Alberta, her long term goal to become a RN was delayed because she could not afford to reduce the number of hours she worked so she could prepare for the SEC/CCA or enrol in bridging education if required. She expressed concern that her friends and family back in the Philippines could not understand how expensive life was in Canada and the challenges she faced. She noted, "I am earning money here but you have to pay for the rent, pay for the bus – I'm earning much – I earning ¼ million if I convert to Philippine money but the people back home don't know that I have to pay for my rent, my bus pass, my food, everything" [Maria, LPN]

For Imelda, an unregulated health worker, the low value of the Philippine peso, and the absence of family in Canada further compounded the problem. She observed:

> Before coming in Canada we only bring a Peso amount. So we cannot just go to CRNM and apply the test without books and materials and you have to be prepared for everything – and you need to survive on the day to day basis so what I did was

> personally I have to be stable first – and since I'm staying with a friend, I have to afford my own place and make sure we're secured. Car is a very important thing. We don't have that when we came here, no money in the bank, so it's really a big factor – money umm – oh God! I can't imagine. It's a big thing! Lucky for them if they have parents already here – sister here – If you're here alone you can never go on with your goals directly even if you wish to. Financial barrier is number one. [Imelda, URHW]

Similarly, a RN, looking back on her experiences with the registration process, commented, "I think when you are coming here it's really part of the immigration requirement that you need to have money and then I think to be a nurse, if you don't have a family here, all of your hard earned money will go quickly" [Hannah, RN].

The financial costs associated with the registration process presented a considerable challenge for many Philippine IENs. The length of time required to complete the registration process as well as tuition costs associated with bridging education were burdensome for some. Furthermore, the high cost of living in Canada taxed the limited financial resources of a number of participants.

Meeting the English language requirements. A total of 29.8% of the RN participants and 45.9% of the LPN participants indicated that meeting the English language requirements of RN and LPN licensure were very difficult or difficult (see Table 20). A Mann-Whitney U Test was conducted to compare the perceived difficulty meeting the English language requirements between RNs and LPNs. The results indicated a significant difference in scores. LPNs found meeting the English language requirements more difficult: LPNs (Md=3.00, n=85) and RNs (Md = 3.00, n= 84), U=2501.500, Z=-3.50, p=.000. r=0.27.

Table 20. Perceived Difficulty Meeting the English Requirements: RN and LPN Licensure

Frequency (%)	RNs	LPNs*	Total*
Impossible or very difficult	3 (3.6)	6 (7.1)	9 (5.3)
Difficult	22 (26.2)	33 (38.8)	55 (32.5)
Neither easy or difficult	22 (26.2)	33 (38.8)	55 (32.5)
Easy	28 (33.3)	10 (11.8)	38 (22.5)
Very Easy or no problem	5 (6.0)	3 (3.5)	8 (4.7)
Not applicable	4 (4.8)		4 (2.4)
Md		3	3
Total	**84**	**88**	**172**

Note. *valid percent LPNs [n=85]; Total [n=169]

During the qualitative interviews, several RN and LPN participants commented on the difficulties they had encountered meeting the English language requirements associated with licensure. A number of participants found the required scores difficult to obtain. Several participants commented that they had to take the English language exam several times in order to obtain the required score, which delayed the process of registration. As one participant commented:

> It is the English exam, it is really very challenging and that is the exam that takes much of our time and makes the process very long. Before I left the Philippines I took an exam and then I didn't get on through the grade that they need so when I arrived here I needed to take it again. [Nicole, LPN]

Another participant described what she perceived as a lack of objectivity amongst examiners on the English language examination. Required to take the English exam for a second time, Victoria questioned the validity of the score she obtained in "speaking" on her second exam. Her appeal was denied and while she obtained the necessary score on the third exam, she noted that the delay slowed down the registration process:

> I took the IELTS I wasn't really happy with the scores. During my first take I lacked .5 for my listening and I got an 8 for my speaking – all the rest were good. When I took it again I got an 8.5 for my listening and but then for my speaking unfortunately it went down from an 8 I got a 6.5. So I don't believe it and I ask them to review it

> and they didn't they said it's really my score and then on my third take I got an 8.5 so I think the 6.5 really doesn't belong to me – so I really don't know. I think it was very subjective. ... I had to wait for a few months [for an appointment] that was the only thing that slowed down my application. [Victoria, LPN]

Similarly, amongst the URHWs interviewed, challenges meeting the English language requirements were frequently cited. The high English language score required by the regulators was frequently cited as a challenge for participants to obtain. Several IENs were aware that the English language requirements had recently been increased and questioned the need for the higher score. Participants felt they had the necessary nursing knowledge and skills to practice in Canada, but in some cases obtaining the necessary English language proficiency presented a significant barrier to obtaining registration as a nurse in Canada. As Dalisay explained:

> Uh I think, you know what Catherine most of the nurses I'm talking to here in Canada, all Filipino, the number one problem really is English. Sometimes I've heard of Filipino nurses taking the IELTS exam for ten times and then they go for CELBAN and three times for CELBAN and they cannot pass it. I don't know, my English now - I guess I'm talking to you - but my level is maybe just a little bit lower than enough - so I don't think we need the higher score for CELBAN or IELTS. It is hard - so how can we get the English scores that we need.... it is really a barrier for us. It's really too high. ... it's really a problem. I volunteered for your study because I'm the voice of so many nurses here and they are encountering the same problem – just like me. Yes really how come they increase the English level but we are so competent -so competent that we can do our job here as a nurse, and the problem it's only English and we can communicate with the patient and I think as days go by and years go by I think we can pick up English, we can practice... Really Cathy the number one problem is English I would attest to that 99%. [Dalisay, URHW]

In 2011, the regulators increased the required score on the listening component of the English language exams. One participant described the difficulty she experienced obtaining the required score on listening, noting a different accent (which she described as "British") and the use of idioms as compared to the English she had been introduced to while living in the Philippines. She stated:

> The language assessment- well- I find difficulty on the listening because it's too fast and especially the British accent is very different. When I have my language proficient exam I need more time on it. Back home the language of school is English the mode of teaching is English. But some of my uh- those who I met at Manitoba START when I was conversing with them they said they think why do they need us to take some English proficiency because back home we speak English but here in Canada it is different. I think here in Canada they have the British whereas back home we follow the American. I think they are more on the idioms – the use of idioms. [Flora, URHW]

Meeting the RN licensure Requirements. Participants also identified a number of challenges specific to the RN licensure process. Undergoing the Clinical Competence Assessment (CCA) in Manitoba and the Substantially Equivalent Competency Assessment (SEC) in Alberta and Saskatchewan, completing the required bridging education, as well as the length of time to complete the RN licensure process were identified as challenges.

The responses from a total of 153 survey participants were included in the quantitative analysis. In addition to the 84 RN participants, 69 LPNs had applied for Licensure as a RN. As well, the responses from 9 URHWs who had applied for RN licensure were included in the qualitative analysis. At the time the data were collected, 46 LPNs and 9 URHW participants indicated that they were currently seeking RN licensure, while 20 LPN participants indicated that they were no longer pursuing registration as a RN (see Table 21).

Table 21. Current Stage in the RN Registration Process – LPNs and URHWs

Frequency	LPN	URHW
English Language Assessment/training	5	1
Credential Assessment	6	2
Competency Assessment	8	4
Educational Upgrading	20	1
Writing the CRNE	7	1
No Longer Seeking Registration as a RN	20	-
Have not Applied for RN Licensure	19	1
Md	3	-
	n=88	n=10

Substantially equivalent competency assessment / Clinical competence assessment. Survey respondents indicated that completing the substantially equivalent competency assessment / clinical competence assessment (SEC/CCA) was the most difficult stage in the RN registration process. A total of 52 RN participants indicated that they had undertaken a competency assessment. Of these, 36/52 (69%) RNs rated the SEC/CCA as very difficult or difficult to complete (See Table 22). Similarly 45 of the 69 LPN participants, who had applied for RN registration, had reached or had completed the competence assessment. Of these 41/45 (91%) LPNs ranked the SEC/CCA as very difficult or difficult to complete (see Table 23). A Mann-Whitney U Test was conducted to compare the perceived difficulty of completing the SEC/CCA for RNs and LPNs. The results indicated a significant difference in scores. LPNs found the SEC/CCA more difficult: LPNs (Md=3.00, n=45) and RNs (Md = 3.00, n= 52), U=711.000, Z=-3.670, p=.000. r=0.37.

Table 22. Perceived Difficulty Completing Competence Assessment – RNs

		Frequency	Percent	Valid Percent
RNs	Impossible or very difficult	6	7.1	7.2
	Difficult	30	35.7	36.1
	Neither easy or difficult	11	13.1	13.3
	Easy	5	6.0	6.0
	Not applicable	31	36.9	37.3
	Total	83	98.8	100.0
	Md	1	1.2	
Total		**84**	**100.0**	

Table 23. Perceived Difficulty Completing Competency Assessment – LPNs

		Frequency	Percent	Valid Percent
LPNs	Impossible or Very Difficult	18	40.0	40.0
	Difficult	23	51.1	51.1
	Neither easy or difficult	3	6.7	6.7
	Easy	1	2.2	2.2
	Total	**45**	**100.0**	**100.0**

Qualitative responses also reflected the challenges many participants experienced while completing the SEC/CCA. When asked, what was the most difficult part of the RN registration process, many participants responded that it was the SEC/CCA:

> it's absolutely the SEC, it's very stressful, I never slept a day for those 5 days ..... So for whole one week it was so stressful I wasn't able to sleep because I was scared as well.... during the exam it's really stressful the questions, the skills demonstrations everything. The first day you will take the exam the second day the skills lab and everything is very stressful. [Sarah, LPN]

Similarly, Nicole commented:

> The hardest part of the RN process – is doing the SEC assessment. With the SEC assessment we just think that it is very comprehensive and we just know that we will end up with a lot of subjects. They want us to perform very comprehensively in each of the subjects, in each of the, what do you call – like maternity, pediatrics, each of the subjects they want us to perform very comprehensively which is so impossible for us. [Nicole, LPN]

The simulated format of the SEC/CCA was also considered difficult for some IENs:

> the written part it is OK but I find it so difficult to do the practical exam because our clinical instructor they were just acting out, pretending to be the patient, pretending to have pain and when they were acting patient complaints it's so different when its real – I really don't have any complaints about the physical exam but I find it difficult, how do you act if the patient needs a CBC.. All right this is ... I have to regulate the IV... when you just have to pretend... it is really so different than when you actually have your duties... when it is real ... I kind of find it very hard for me... I don't know about the others. [Michelle, RN]

English language proficiency was also cited as a challenge when undertaking the SEC/CCA. As Anna explains:

> It was very, very hard. For me it was harder than taking my NCLEX exam. I never want to take this exam again. The hardest part about it was the practical exam. I'm good with the written test. I think I did really good on those but the practical exam - It scared me. #1 I'm not really comfortable speaking English when I first came here. It was really hard for me to express all that was in my head. I had to think in my language and translate as fast as I could so that part was really - I really thought I would never pass that. I was a little intimidated by the nurses who were doing the exam – they were really – it feels like it was really real. [Anna, RN]

Others commented on the perceived unfairness of the SEC/CCA and questioned the objectivity of the assessment outcomes. Several participants noted that while they felt the written multiple choice exams were objective, the practical assessment outcomes were subjective and varied depending on the assessor. As one participant wrote on the survey, "The SEC assessment that is mandatory before being a registered nurse in Canada is very SUBJECTIVE not Objective as it must be.... results of assessment is very dependent with the Assessor making such assessment a Traumatic experience for IENs like me" [Y.E. RN]. Similarly, another IEN who participated in a telephone interview stated:

> how they assess the individual, it's very subjective, it depends on the assessor. I've known people who have to take a four year course and it's very hard for them. Umm it really depends on the assessor – if the assessment is writing the exam - then it's fair because there is an exact answer to each of the questions. [Researcher: So you think the exam is subjective?] Yes, I think so, that is what I believe. [Vince, LPN]

Still others perceived that IENs from the Philippines were referred to the SEC/CCA more often than IENs from other countries; one individual wrote, "as an [IEN] (from Philippines) we feel we are not treated as equal as regarding getting a Sec assessment as compared to [IENs] from other countries" [K. L. LPN].

As the following comments demonstrate, the outcome of the SEC/CCA and the subsequent need to enrol in bridging education deterred several LPNs from continuing through the RN registration process. One LPN noted that, following the SEC/CCA, she was told that the gaps in her knowledge, skills, and competencies did not meet the RN standard in Canada and could not adequately be addressed through bridging education. In her words, "As a registered nurse in the Philippines, I wanted to become an RN here as well. Unfortunately I did not pass the SEC Assessment exam required by CRNA to get me into the bridging program" [L.P., LPN]. Similarly, online survey data revealed that the outcome of the SEC/CCA was a notable point

of attrition from the RN licensure process amongst LPN participants. A total of 20 LPNs indicated that they had applied, but were no longer seeking registration as a RN. While 16 of these 20 participants reached the stage of completing a SEC/CCA, only 6 continued on to a bridging program.

Concerns regarding the fairness of the assessment process, as well as the potential outcome of the SEC/CCA were also cited as the main reason some LPN participants chose not to pursue licensure as a RN. One LPN indicated that she had not applied with the RN regulator because, "The SEC assessment is unfair. Going back to school would not fit into my work schedule. Courses are expensive" [A.B. LPN]. Others simply stated their main reason for not seeking RN registration was "The SEC Assessment" [L.M., LPN].

Bridging education. Enrolling and completing the required RN bridging education was identified as a challenge by a number of participants. A total of 39 RNs indicated that they had completed a Bridging Program. Of the 33 RN responses, data from 3 participants were incomplete leaving 30 responses for analysis. An additional 32 LPN participants indicated that they had enrolled in a Bridging Program as part of the RN Licensure process. These responses were included in the analysis. Of the 62 responses analyzed, 56.5% of LPN and RN participants (n=35) indicated that enrolling in bridging education was difficult or very difficult (see Table 24).

Table 24. Perceived Difficulty Enrolling in RN Bridging Program

	RNs	LPNs	Total
Impossible or Very Difficult	4 (13.3)	10 (31.3)	14 (22.6)
Difficult	10 (33.3)	11 (34.4)	21 (33.9)
Neither easy or difficult	10 (33.3)	11 (34.4)	21 (33.9)
Easy	5 (16.7)	-	5 (8.1)
Very easy	1 (3.3)	-	1 (1.6)
Total	**30**	**32**	**62**

The challenges associated with enrolment were further described in the qualitative comments provided by a number of survey participants. The length and cost of bridging education were the most frequently identified barriers to enrolling in programs. One LPN commented:

> THE NEXT THING WOULD BE FINDING TIME TO STUDY AND WORK AT THE SAME TIME, HAVING YOUR VACATION REQUEST APPROVE WOULD BE DIFFICULT…. IT IS ALSO HARD AND A LONG PROCESS TO OBTAIN BACK YOUR DEGREE AS RN SINCE THEY REQUIRE YOU WITH SO MANY CREDENTIALS AND UPGRADING COURSES WHICH ARE THEN ONLY OFFERED IN A SPECIFIC TIME AND WITH NO SPECIFIC SCHEDULE. IT TOOK ME 2 LONG YEARS TO OBTAIN MY RN DEGREE BECAUSE OF TOO MANY COURSES AND THEY OFFERED THE COURSES IN A NOT SO TIMELY MANNER.I AM NOT SAYING THAT COURSES OR BRIDGING PROGRAM ARE NOT HELPFUL BUT AT LEAST GIVE US THE INFORMATION ON HOW THEY COME UP WITH THOSE RESULTS WHICH WILL THEN GIVES US AN IDEA ON WHY DO YOU HAVE TO TAKE THOSE COURSES. ANOTHER FACTOR IS FINANCIAL DIFFICULTY, MOST OF US CAME IN HERE TO WORK IN ORDER FOR US TO SUPPORT OUR FAMILY AND GETTING YOUR DEGREE BACK IS A LENGTHY AND COSTFUL PROCESS. [D.B., LPN, Capitals in original]

Similarly, another survey participant remarked that enrolling in bridging education and maintaining family financial responsibilities was very difficult. She wrote, "the nursing here in Canada has required us IEN's who are not trained in the US to take 10 subjects in nursing that would require you to study online, which is very difficult for persons who are providing for their family as well" [V.X., LPN].

While the length and cost of bridging programs were identified as challenges, long wait lists and the location of bridging programs were also discussed. One participant commented:

> Waiting for entry in the Bridging program – I have to wait until January 2014. Takes a long time to get the schedule – I applied with the [regulator] in December 2011 and then they got me in for my assessment October 2012 – so it took me 10 months just to get assessed – just to get the schedule. Then wait until January 2014 for bridging. [Malaya, URHW]

Another IEN, residing in a rural community, decided to no longer pursue his RN Licence when he was referred to a bridging program. Unable to move to a city to attend a bridging program, he chose to pursue LPN licensure instead. He stated, "umm they recommend some courses – yeah bridging – yeah it was really really still long for me and I can't afford to be full time. And we're living in [rural community].[Researcher: And you couldn't move?] Yeah" [Ramon, LPN].

A slightly lower percentage of both RN and LPN participants found completing the academic requirements of bridging programs difficult or very difficult. Data from 30 RNs who had taken bridging education indicated that 12 (40%) found it was difficult to meet the academic requirements. No RN participants reported that it was very difficult to meet the

academic requirements. A total of 20 LPNs indicated that they had or were currently completing the academic requirements of a bridging program. Of these, 6 (30%) participants ranked meeting the academic requirements as difficult or very difficult (see Table 25).

Table 25. Perceived Difficulty in Academic Performance in RN Bridging Program

	RNs	LPNs	Total
Impossible or Very Difficult	-	1 (5.0)	1 (2.0)
Difficult	12 (40)	5 (25.0)	17 (46.0)
Neither easy or difficult	11 (36.6)	11 (55.0)	22 (44.0)
Easy	5 (16.7)	3 (15.0)	8 (16.0)
Very easy	2 (6.7)	-	2 (4.0)
Total	30	20	50

Several participants commented that it was the length and pace of the program, rather than the difficulty of the material, that was challenging. During the telephone interview, one RN participant spoke of her challenges taking the bridging program course work. She remarked, "The bridging program itself – being a student again after so long, it was so fast and so intense that when I was doing it I thought I would burn out" [Grace, RN]. Another interview participant remarked that the number of courses made completing the academic requirements challenging: "I am currently taking the subjects that I got after I took my SEC assessment, it is from the SRNA, they gave me 11 more subjects, plus clinical, so I am currently at my very first subject as a part time student… I think 3 years, the maximum, that's the time frame to finish everything" [Nicole, LPN].

Passing the national licensure exam. Writing the National Licensure Exam was identified as a challenge by a number of survey participants. A total of 36.9% of RN participants indicated that passing the Canadian Registered Nurse Exam (CRNE) was very difficult or difficult (see Table 26).

Table 26. Perceived Difficulty Passing the National Licensure Exam

Frequency (%)	RN –CRNE
Impossible or very difficult	6 (7.1)
Difficult	25 (29.8)
Neither easy or difficult	30 (35.7)
Easy	17 (20.2)
Very Easy or no problem	6 (7.1)
Not Applicable	
Md	
Total	84

Caught in an endless loop: Delays in the Registration process. Although the survey data revealed that the majority (73.8%) of applicants to the RN licensure process were able to complete the process in less than two years, approximately one quarter (26.2%) of RN participants required over two years to complete the registration process in Canada (see Table 27).

Table 27. Length of Time to Complete the RN Registration Process

	Frequency	Percent
< 1 year	39	46.4
1 year - < 2 years	23	27.4
2 years- < 3 years	9	10.7
3 years - < 4 years	9	10.7
4 years - < 5 years	4	4.8
Total	84	100.0

Delays at several points during the registration process were described by participants. Delays in accessing English Language programs, delays in the processing of documents, delays in obtaining an appointment for the SEC/CCA, and delays in enrolling in bridging education were all cited by participants (see Figure 10).

"The English – A lot of people said – it's the English that's the hardest part because you can never study - MNU is really a big help but the thing is there are only very limited slots for them. ..... There's only 15 slots per season. So you really have to wait. ..... I waited 7 months to get into the MNU course" [Imelda, URHW], describing the challenges she encountered gaining entry into an English language program offered by the Manitoba Nurses Union (MNU)]
"The major thing was the waiting period to process the papers. I started Dec. 2010 with the [Regulator], I got my CCA referral Feb. 2011. Umm I was able to go to CCA July 2011 and I know that I didn't pass September 2011 and I have to go for the bridging program but umm there is struggles come along again. I am on a working permit then and there were only 2 slots for people on a working permit- so I can't go to the bridging program – the only slot they give me is Jan. 2013. It was a long wait." [Patricia, RN]
"The long period of waiting overall and the scheduling for the examination for the English as well as the schedule for the CCA. You know you only have two years for your English and then your English expires but it takes 6 months to one year to take examination." [Lilibeth, URHW]
"My husband he was here first and he inquired already about what needs to be done. So I started already, back home in the Philippines, with IELTS so when I came here I would have these paper works to present. And then when I got here I went to the [Regulator] and asked myself what things to be done. And they told me as a start it would be IQAS so I had to pass all my papers from my college from where I was a student and then I had to wait for that – there was a lot of waiting time as well. And after IQAS I had my IELTS which were still good at that time. And then after that I had to wait for my assessment exam and after the assessment exam I had to wait again for the bridging program. At that time I was trying to make it for the earliest class and they said I can't go in that because it's filled up already so I had to go to the next. I waited almost a year for the bridging program" [Grace, RN]

Figure 10. Delays completing the registration process.

Delays lengthened the amount of time required to complete the registration process and, as a result, a number of participants were required to resubmit documents that had expired before their registration was complete. For many participants resubmitting expired documents added additional expense to the licensing process and further delayed entry into the workforce as a RN. Of the 84 RN participants who completed the online survey 26/84 (31.7%) indicated that resubmitting expired documents was very difficult or difficult (see Table 28).

Table 28. Perceived Difficulty Resubmitting Documents That Expire During Registration

	Frequency	Percent	Valid Percent
Impossible or very difficult	11	13.1	13.4
Difficult	15	17.9	18.3
Neither easy or difficult	12	14.3	14.6
Easy	5	6.0	6.1
Very Easy or no problem	1	1.2	1.2
Not applicable	38	45.2	46.3
Total	82	97.6	100.0
md	2	2.4	
Total	84	100.0	

Qualitative comments received during the telephone interviews highlighted particular difficulty resubmitting expired English Language scores. Difficulty scheduling the English examination as well as the expense of repeated testing was mentioned by a number of participants. At times participants had to travel to another province to schedule an exam. As one participant noted, "At first I didn't have to wait too long but now in Regina we don't have CELBAN, we only have IELTS and usually once you've registered it will take 4-5 months to get the exam. So people drive to Manitoba or Calgary just to get the CELBAN exam" [Nicole, LPN]. Another participant had tried unsuccessfully for several months to schedule an exam in Winnipeg. Frustrated, she looked toward Calgary and Edmonton, a distance of more than 1200 Kilometres away, for an examination date. She commented, "the thing is - not only here in Winnipeg - I've been trying to write the English thing - and I've also been trying to schedule in Calgary and in Edmonton because its high volume here in Winnipeg so the schedule for taking the examination is kind of hard for me and we've been waiting here so very long" [Lilibeth, URHW].

While participants recognized the need for English language proficiency, many questioned the need for repeated testing. One IEN, who had been living in Canada since 2008 and working as an LPN since that time, was required to be retested for English language proficiency as her test expired before she completed the RN licensing process. In recounting her experience, she questioned the value, or in her words the "sense," of having to take another English language test:

> My thing is we are here working as nurses, as LPNs, and we have been here for a while and I do not know how it is and I don't think this is the right thing to do to have Filipino nurses and nurses from other countries – [retested for English] because we are already here. We've been working here but they are requiring us to pass the exam when we already pass it once it does not mean that we do not know how to speak English right away if that exam expired – right – I do not see any sense about it.. They should have given consideration, let me say, if you are already working here for several years you should have some exemption. Like we are already working here for quite a while and you will still require us to go through the IELTS exam – it just doesn't make sense.. and it's kind of expensive to take it and there is a waiting list. [Joan, LPN]

Although the challenges associated with expired English tests were the most frequently discussed, participants also noted that the expiration of other documents presented an added challenge. Hannah had previously been registered in three other countries before moving to Canada and was required to submit a verification of registration form for each of the three countries. Once submitted, the verification of registration was valid for one year. She described the difficulty this created and questioned the "sense" of the policy. She stated:

> Because I have 3 licenses I think they were asking me every 6 months to renew it – I have to send another form, pay again and verify my license. Continuous updates – and I say [to myself] how come I have to update it like this, I'm already here in Canada and I am not working there and I think it doesn't make sense to me – and I don't know how anything could happen when I'm not working there. Umm I think they should only verify licenses once... I don't really get it. [Hannah, RN]

For a small number of participants, repeated delays and the subsequent expiration of documents created an endless loop. They would finish one requirement, only to discover a previously met requirement had expired. This cycle is best exemplified in Lilibeth's story. Lilibeth first applied for registration as a RN in 2009. She was referred for a SEC/CCA and was required to complete a bridging program. In October 2011, upon completion of the bridging program, she wrote the CRNE but did not pass. When she applied to write the CRNE a second time, she was told her English test had expired and that she had to resubmit an English Language Test before rewriting the CRNE. Since submitting her first test in 2009, the language requirements had increased and Lilibeth did not meet the increased score on re-testing. She enrolled in English language training, but in June 2012 was told by the regulator that she had to meet the language requirements by a certain deadline or her application would be closed. In her words, "they gave me a deadline, if I didn't pass the English I would not be able to write the second CRNE and they will close my application and then they will um they will make me apply again – unfortunately that is what has happened to me"[Lilibeth, URHW].

Although Lilibeth subsequently met the new English language requirements, she was

unable to do so by the regulator's deadline. When she approached the regulator, she was told her file had been closed. Faced with the prospect of reapplying, she simply stated, "I can't afford to pay another registration fee again um its burdensome for me to pay another registration fee"[Lilibeth, URHW]. Lilibeth has recently opened an application with the College of Licensed Practical Nurses and is waiting to hear if a competence assessment is required.

Section Five: The decision to work as a LPN, RN or URHW

> **Research Objective: Identify the factors that influenced the Philippine nurse's decision to work as a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Unregulated Health Worker (URHW) in Western Canada.**

Intention to work as a Registered Nurse in Canada. The LPN and URHW participants were asked if they had applied for registration as a RN since arriving in Canada. The majority, 78.4% of LPNs and 90% of URHWs, had applied with a RN regulatory body for licensure. The remaining 20 participants (19 LPNs and one URHW) indicated that they had initially intended to apply for licensure as a RN. Thus 100% of participants indicated that they had applied, or had initially intended to apply, for RN licensure upon migration to Canada.

Decision to work as an unregulated health worker. In addition to the 10 face to face interviews that were conducted with URHWs, qualitative data were collected from survey participants. Of the 172 IENs who completed the survey, 44 LPNs and 26 RNs indicated that they had worked as an URHW before becoming licensed as a nurse. A total of 66/70 participants provided qualitative responses that discussed their decision to work as an URHW in Canada.

"Survival job". The primary reason cited for working as an URHW was to provide financial support for themselves and their families as they proceeded through the licensure process. The length of time and the cost of registration required many IENs to seek employment. One participant remarked, "Being an immigrant, I had to find a job that is closest to my profession, and that is being a care aide. This enabled me to feed myself, pay the bills and pay the necessary fees for my LPN registration" [H.P., LPN]. Another noted, "[i] need an entry work to sustain life in Canada and continue supporting my family.....and.... no choice, have to earn money to cope up with the Canadian system of upgrading your education to be a

part of the Canadian workforce" [Y.E., RN]. In addition to providing for their own financial needs, many IENs were helping to support their family and were sending remittances back to the Philippines. J.R. wrote, "I have to help my spouse with our daily basic needs and support our siblings in the Philippines, and we have to send our only daughter to school" [J.R., RN].

The high cost of living in Canada and the value of the peso as compared to the Canadian dollar quickly drained the financial resources of a number of new immigrants. Imelda described how life in Canada was much more expensive than she had anticipated and the money she brought from the Philippines was not adequate to cover all the expenses associated with licensure:

> Before coming to Canada we only bring a peso amount. So we cannot go to CRNM and apply for the test without books and materials – you have to be prepared – and you need to survive on day to day basis… I have to afford my own place and make sure we're secured. Car is a very important thing. We don't have that when we come here, no money in the bank, so it's a big factor – Money ummm Oh God! I can't imagine. [Imelda, URHW]

Finding a job was not easy for Imelda. Initially the only work she could obtain was in a housekeeping position. She described feelings of low self-esteem and depression and felt grateful when she eventually found a job as a URHW:

> When nobody called me yet or asked for my interview I applied as a janitress and it's really, really hard. A lot of depression, a lot of low self-esteem but later on… I am really grateful as I am able to survive in our day to day basis working as a caregiver right now. [Imelda, URHW]

For some participants meeting the English language requirement for licensure was difficult to obtain. Without the necessary scores, they were unable to begin the application process, which prolonged their work as an URHW. As Dalisay explained:

> Most of the nurses I'm talking to here in Canada – all Filipino – the number one problem is really English. Sometimes I've heard of Filipino nurses taking the IELTS exam for ten times and then they go for CELBAN three times and they cannot pass it…my level is maybe just a bit lower than enough…I volunteered for your study because I'm the voice of so many nurses here and they are encountering the same problem just like me…the problem it's only English. [Dalisay, URHW]

Choosing employment as a URHW over other jobs. Amongst participants working as an URHW was preferred over other jobs as the wages were higher than many entry level positions. A number of IENs remarked that they were working or had worked as an URHW as

it "[had] better pay compared to minimum wage jobs" [N.R., LPN]. In addition to higher wages, several participants commented that working as a URHW was closer to nursing and provided an opportunity to utilize at least some of their nursing knowledge and experience while learning about the health system in Canada. As Tala remarked:

> Before I became a HCA I worked in a fast food chain, and I see the difference in the fast food you only earn basic and you are also tired, so tired. It's fine there but as a nurse you know the feeling of missing the hospital – you know – missing everything you did before. So I entered Health Care Aide just to incorporate all that I learned before and how the Canadian Health Care system is. It's like I'm entering the profession little by little. [Tala, URHW]

Similarly, Arvin described how the role helped him learn about nursing in Canada and gain valuable hospital experience:

> I'm working in the hospital right now, yeah specifically I'm a HCA in Emergency at XX hospital so it's not just the money, I'm learning. So its two things. I love it there because they do everything there from assessment interviews to IV's everything so I'm very much grateful that I'm employed and learning. Every time I talk to the nurses over there, my colleagues in emergency, they were asking me what was my job back home and I said to them I'm a nurse. But even though I'm a nurse back home it's different than what you have here. The health care system – everything's different. It's not that I know everything. If I were to work as a nurse right now it would be difficult, it would be challenging. So it's a good thing that I work as a HCA so I can see everything – especially in the ER. [Arvin, URHW]

Several participants indicated that working as a URHW would assist them to find employment once they became a nurse in Canada. Experience in Canada, gaining seniority, and establishing connections were all discussed. Luzon remarked, "I work as a HCA primarily because it's closer to my profession and when I get to the institution – like when I become a nurse it will be easier for me to get in as a nurse.. because they will have my files, they will have my records" [Luzon, URHW]. And B.F. wrote, [I worked as a URHW] "to learn more about the Canadian healthcare system, to obtain experience and to have a network of health care professionals that will come in handy when applying for other health care jobs" [B.F., URHW].

The decision to work as a Licensed Practical Nurse in Canada. In addition to the 88 LPNs who participated in the survey, 16 of the RN participants reported that they had worked as a LPN in Canada before becoming a RN. A total of 98 (82/88 LPNs; 16/16 RNs)

participants provided qualitative responses that discussed their decision to work as a LPN in Canada.

Challenges encountered during RN licensure. The challenges associated with the registration process were identified as the primary reason for choosing to work as a LPN in Canada. The length of time required to complete the process and the costs associated with RN licensure compelled many IENs to seek employment as a LPN. Participants described an easier and shorter LPN licensure process, the opportunity to gain experience working in a Canadian health care setting, and good wages as reasons for pursuing registration as a LPN. As one participant remarked:

> Although my primary goal was to become a Registered Nurse here in Canada, I worked out for the LPN pathway first … It is faster to get into Licensure exam for LPN because there was only Ethics subject as a prerequisite [and] I have a family to feed and bills to pay, so getting into a better job in terms of salary was considered a wise decision for me. [X.B., LPN]

Similarly another participant commented:

> They say applying for RN will take a lot of preparation, both financially and mentally and the application time takes about 2 years. For someone who just arrived here in Calgary, I cannot wait that long and be in a job not related to my profession. Applying for LPN gave me the opportunity to be back in my profession the soonest possible time, earn for the family, gain some Canadian Nursing experience, while preparing for my RN licensure. [V.Z., LPN]

Several participants commented on the benefits of working as a LPN while working toward a RN license. For one participant, the LPN role provided an opportunity to become "familiar with [the] Canadian health care system" [P.W., RN]. For another, the role was an opportunity "[to have] a higher salary than health care aide" [J.X., RN]. It also allowed IENs to use their nursing knowledge, skills, and abilities in a Canadian healthcare setting. As W.Y. remarked:

> Being away from profession for two years makes feel unfulfilled and such a waste of learnings, skills and nursing experience. I really wanted to go back and work in the hospital once again. A higher pay as well is one of the factors in order for me to have enough resources to cover any expenses for the education needed in order for me to become an Operating room nurse or Emergency Room nurse. [W.Y., LPN]

Choosing a career path. Participants described three different career paths. For some IENs LPN licensure was a stepping stone to RN practice in Canada, while others chose to seek both RN and LPN licensure as a parallel process. Still others chose to work as a LPN as an alternate career to RN practice.

Stepping Stone. Some participants applied for their LPN license first, describing it as a "stepping stone to become a Registered Nurse" [G.H., LPN] in Canada. As V.Z. remarked, "I decided to first apply for LPN and then later apply for the RN. CLPNA has really been supportive and they answer to almost every questions you ask them. They are just simply ready to help" [V.Z., LPN].

Likewise, X.V. saw her LPN license as a first step and planned to pursue RN licensure in the future:

> I thought of improving status from health care aide to RN, but the RN process was difficult so I decided to become LPN first. Aside from the salary, i have an ambition to uplift myself, family and my family in the future. So im not going to stop at LPN, i want to continue to study as far as my money and time can go. [X.V., LPN]

Parallel process. Others applied for both LPN and RN licensure simultaneously, receiving their registration as a LPN first. As E.I. expressed, [it was] "Hitting two birds with one stone- I applied for both LPN and RN status to get a job right a way while waiting for my RN exam" [E.I., LPN]. Likewise, Victoria, anticipating the need to complete bridging education and a lengthy process for RN licensure, decided it was worth the added expense of applying for both licenses at the same time. In doing so, she would be able to work as a LPN while completing the requirements for RN registration and, if she failed to meet the necessary requirements to become a RN, she would have another career option:

> Well I heard from many Filipinos who were working here first before me that sometimes it will take a while before you get your license, before you will be allowed to take the exam for the CRNE and so what I did was I didn't mind spending more so I just applied both I applied together LPN and RN and that was just for my backup it was my plan B. LPN is my plan B just in case they would tell me to go back to school and get some refresher courses. [Victoria, LPN & RN]

Victoria went on to explain that in fact she did not require any bridging education and consequently only worked as a LPN for five months before getting her RN license. Even though she received both licenses just months apart, she remarked, "I still made the right decision" [in applying for both at the same time] [Victoria, LPN & RN]. However, the

implementation of a SEC/CCA in 2012 by the CLPNM caused one URHW participant to question if this would continue to be the case. As Imelda recounted, "two weeks ago I received a letter from them [CLPNM] that everyone should undergo a CCA. Somewhat like the RN. As well, and the thing is, with the CCA there's a long waiting list as well" [Imelda, URHW].

Alternate career path. For a number of participants, the challenges encountered while pursuing RN registration led them to choose an alternate career as a LPN. For some, the challenges were too difficult to overcome. For others, they were unable to meet the requirements for RN Licensure. The need to enroll in bridging education was identified by a number of participants as the primary reason they were no longer seeking RN licensure. As T.X. remarked, "I initially wanted to be an RN. But the assessment process gave me 8 online courses to take which would cost a lot of money and a lot of my time. So I decided to be an LPN instead" [T. X., LPN]. Other participants remarked that a lack of recognition of their credentials prevented them from obtaining RN Licensure. E.C. commented, "I want to work as an RN, unfortunately, Canada does not recognize my diploma, being an LPN is my next resort" [E.C., LPN]. Similarly, T.R wrote:

> I didnt have any other choice. As much as i wanted to become an RN, there has been alot of struggles and frustrations to becoming one. I could not just understand why they are giving us,international nurses, a hard time upgrading when in fact i firmly believe that we have the skills and the compassion. It is also degrading on our part, that even nurses from the philippines with master's degree are given no credit at all. [T. R., LPN]

Several participants indicated that they were unable to meet the English language requirements for RN registration but their language scores were sufficient to meet the LPN requirements. As Christina remarked:

> I did both SALPN [Saskatchewan Association of Licensed Practical Nurses] and SRNA [Saskatchewan Registered Nurses Association], I submitted all the requirements for both. And the English test however, I was not able to meet the criteria for the English proficiency score for SRNA however SALPN considered my score and accepted it and gave me the go ahead to be enrolled in ethics subjects after that I took the Registration exam. Whereas as SRNA didn't accept my English. [Christina, LPN]

Other participants, anticipating challenges with the RN licensure process, chose not to apply, instead pursuing an alternate career as a LPN. One participant remarked, "They say applying for RN will take a lot of preparation, both financially and mentally and the application

time takes about 2 years. For someone who just arrived here in Calgary, I cannot wait that long and be in a job not related to my profession" [V.Z., LPN]. Another commented, "I was discouraged as to the many difficulties my friends has to undergo during the upgrading process... Especially with the requirements and the length of time CARNA have to process the papers before.sec assessment is being scheduled" [P.Q., LPN]. Similarly, another participant noted a "Lack of time, we have to work full time to privide out daily needs and subsistence and english exam has a very high standard score to pass though its not our first language:(" [L.N., LPN]. Finally, U.Y. explained, "Initially, I intended to apply for registration as a RN but the process takes a very long time and we have to undergo bridging programs which will cost money and time, unlike applying for registration as LPN, the process takes only a short amount of time and less expenses" [U.Y., LPN].

Active recruitment. In 2008, Health Authorities in Alberta actively recruited RNs. A number of IENs entered Canada as TFWs and their work permits entitled them to work as LPNs or URHWs. For some participants their active recruitment and the subsequent conditions of their work visas were the primary reasons cited for working as URHWs or LPNs. Riza, for example, was recruited to Canada by a recruitment agency in 2008 and her initial entry visa was valid for two years. When asked if her initial plan was to work as a RN in Canada, she replied; "Yes, of course that was the goal. That's still the goal. My entry visa only allowed me to work as an HCA or home care support. I came to Canada because I was hired as a nursing assistant – at that time that was my position… I couldn't work as a nurse" [Riza, URHW].

A number of the IENs reported that the work permits they had been issued limited their work, at least initially, to a URHW role. Although for some their work as a URHW had been relatively brief and within one year they had been able to obtain licensure and employment as a LPN, this was not the case for everyone. Riza encountered a number of obstacles delaying her ability to pursue licensure. She explained:

> I went through the LPN assessment and everything and then I found out as an international student I have to pay 2.4 more – 2.4 times more than a Canadian resident for tuition… I thought, Oh No! Where am I going to get the money? Too much money - I'm not earning as much money – I'm only earning like minimum wage and my time would be split between studies and work and I was thinking how am I going to be able to do that and survive… I backed out of my LPN course. [Riza, URHW]

A number of IENs also commented that they felt they had not been given adequate information prior to migration and expressed anger, as they felt they had been misled by the recruiters:

> It was government recruitment I believe it was Alberta Health Services yeah so I think what they did was they, they partnered with an agency. That agency has a branch in the Philippines and it was the agency who recruited the Filipino nurses in the Philippines. [Researcher: What were you recruited as?] At first, actually the first position that they offered us was Health Care Aide but then later on it was upgraded to LPN and we were made to believe that after we were here it would be easy for us to convert or upgrade into Registered Nurses. [Researcher: When they first told you that you were hired as a HCA were you comfortable with that?] Yes because they told us it was only our entry and that when we were here we could work on our RN licenses like we were made to understand, my personal opinion, we were made to understand that it would be easy….I don't like, personally I don't like, that when we were here first, [pause] back in the Philippines we were made to understand that we could upgrade to a Registered nurse and it would be easy but when we were here, it's only then that we become aware of the SEC, the skills, competency test – we were not informed of that back in the Philippines so when we came we were surprised that we would have to do the SEC exam before we could challenge the RN exam. [Joan, LPN]

M.N. expressed similar concerns:

> I was hired by then Capital Health way back in 2007! As I came in November, 2008. My employer didn't give us any idea before arriving in Canada what their expectations are, as well as informing us what we will be expecting! As I arrived in Edmonton in a group, it was chaotic! Nobody is guiding us what we will do, just a bunch of letters in an envelope informing us what we will do! It was difficult! We had a temporary license as an LPN from CLPNA until we pass our exams…. As far as I am concern I am an RN in the Philippines and the Canadian system is not recognizing it. The reason that I hear from my employer was that we lacked two years of education and our equivalent is of an LPN…. It's very difficult and time consuming to upgrade as an RN. [M.N., LPN]

Another participant, remarked that once she arrived in Canada and learned of the requirements for Registration as a RN, she was reluctant to invest financially in RN licensure until she knew she could stay in Canada as a permanent resident: "[I] worked as LPN instead of RN, during the 1st 1-2 years our status is not so sure if to become a permanent resident or not, that's why I did not want to spend money to upgrade to RN rather than to be sent home after the contract is finished" [C.E., LPN].

The active recruitment campaigns were not viewed negatively by all participants. For some, they provided a means to enter Canada. Maria commented that while she did not realize she was being recruited as a LPN, the recruitment provided her with an opportunity to leave the Philippines and migrate to Canada. She remarked, "I didn't know I would be an LPN – all

I know is I would be working here as a nurse but I thought it would be RN…. I don't care if I'm paid commensurate to my experience – I just wanted to get out of the Country" [Maria, LPN]. Similarly, R.S. wrote, "My employer hired me as an LPN in the Philippines. I use this opportunity given to me to immigrate in Canada" [R.S. LPN]. Another participant noted that being recruited as a LPN provided "a stepping stone for me to migrate in Canada" [P.W., RN].

All of the IENs who had been actively recruited as LPNs or URHWs were from Alberta and arrived in Canada in 2008 or 2009. No IENs from Manitoba or Saskatchewan reported a similar experience.

Section Six: Entering the Regulated Nursing Workforce in Canada - Pre-licensure Supports

Research Objective: Identify the supports that nurses from the Philippines utilized while entering the Western Canadian workforce.

Both formal and informal resources were identified by participants as helpful sources of information and support throughout the licensure process. Family, friends, IENs, and members of the Philippine community were identified as informal sources of information and support, while the nursing regulators, recruitment officers, employers, preceptors, the nursing union, government services, and bridging education were formal sources of information and support for participants.

Informal supports.

Family and friends. Family and friends were identified most frequently by participants as being the most helpful source of information and support while becoming a RN or LPN in Canada (see Table 29). Family was identified by a total of 82% (valid %: n=167) of participants and friends were identified by 78% (valid %: n=166) of participants as either very helpful or quite helpful. Qualitative comments expressed during face to face and telephone interviews confirmed the support provided by family and friends. Family and friends provided participants with information about the registration process. Nicole learned about the LPN designation from her sister who had migrated a year earlier: "Umm my sister arrived here a year before us and she is an RN and she is the one who just told me about it – I didn't have any idea about it before" [Nicole, LPN].

Similarly, Lilibeth described how her husband, who was already living in Canada, provided her with information regarding RN registration: "Before I go here, umm my husband inquired regarding the possibility of my pursuing nursing in Canada. So he asked some of this friends and then they told us to go to the CRNM and we made a request" [Lilibeth, RN]. Likewise, Tala received information from her aunt: "[Researcher: how did you find out about the Registration process?] My Auntie was here and she was here for almost two years and she knows already because she is a Registered Nurse" [Tala, RN].

Although family members were frequently the initial source of information regarding the registration process, the information received was sometimes inaccurate or incomplete. Flora explained how her aunt had encouraged her to apply for licensure as a LPN, as the process would be easier. When Flora applied, however, she discovered that the requirements had changed: "Well my aunt told me why not take the LPN because there is no CCA at that time – it's easier you will just take exam but by the time I applied they have CCA [laughs]" [Flora, URHW]. She also explained how she had received information from her cousin in Canada before migration, but the information had been incomplete. With more complete information, she felt she would have been more prepared to meet the requirements for registration upon arrival: "OK these are the things to make the process more faster. Take English proficiency and then if you meet the requirements maybe you can start applying because I think CRNM will accept your application… That's what I miss, cause my cousin didn't know, so…." [Flora, URHW].

In addition to providing information, family and friends were a key source of support. Participants described living with family or friends when they arrived in Canada: "I'm staying with my friend" [Imelda, URHW]; "We are living with our Mother-in-law right now" [Lilibeth, URHW]. Participants also spoke of the support received from family and friends. In overcoming the many challenges of licensure, Patricia felt tremendous support from her husband: "A lot of struggles coming through but I think it's all worth it and my husband is very supportive, I can't imagine how supportive he's been when we first moved" [Patricia, RN]. Another participant commented that she had chosen to live in Alberta as she knew she would be able to get support from a family friend upon arrival: "um so I contacted my aunt, she has a friend here in Alberta and then she offered to help us here in Alberta and that's why we're here" [Sarah, LPN].

Family members back in the Philippines were also identified as an important support in obtaining original documents required by the nursing regulators. One participant remarked how helpful her sister had been in helping her obtain the necessary documents from the Philippines:

> When I applied, only about a week [later] they replied me that I have to do this and to do that. So I sent all the forms back home then uhh I requested my sister to follow up because the agency is the one who has to mail it back… I gave her some money because agencies back home they're not the ones, they're not responsible for mailing documents so I just told her that as long as address from agency is on send it to CRNM so she facilitated the sending. [How difficult would it have been if you hadn't had someone there?] I think it would have take 6 months to one year. No one would follow up. [Flora, URHW]

Likewise, another participant commented:

> I have to retrieve certain documents back home from my school and from my employers there and then send it back to them and then another document to send back home and then send here. I ask my sister and my mother back home to figure all the documents I need to send here. It will be hard [if I didn't have anyone in the Philippines]. [Pearl, LPN]

It is important to note that although the majority of participants identified the presence of family as a positive source of support, one participant felt the absence of family and the associated responsibilities was an advantage, as she could focus her time and money on completing the registration requirements. She explained:

> I'm single, I don't have kids, I don't have a husband that's like bugging me all the time to do something other than studying. I think it's one of the factors that helped me do well in here….I think the first thing you should be doing is not to bring your family if you are not yet registered. That is one of the concerns - because you are taking care of your kids and you know gonna fail -it's another frustration and then you know writing the second time it's going to be a lot of stress and there is a lot of stress already, the stress is so high. You have your kids, you have your husband and they are relying on you as well….Then when they have their license they can bring their family. [Bea, RN]

Members of the Philippine community and other IENs. Members of the Philippine community and other IENs were also identified as sources of information and support. A total of 71.8% (valid %: n=160) of survey respondents indicated that the support they had received from other IENs has been very or quite helpful and 47.6% (valid %: n=166) of participants ranked the support they had received from other members of the Philippine community as very or quite helpful (see Table 29). Qualitative responses confirmed these findings. Analyn noted that speaking with classmates in an English Language class for IENs she had found out about the application process for RN Registration and connected with the exam preparation workshops offered by the Philippine Nurses Association of Manitoba (PNAM). "my

classmates are processing their applications [with the nursing regulator], also umm they are doing workshops with PNAM too, that's how I found out" [Analyn, URHW]. Similarly, after enrolling in bridging education Angelica made some helpful connections with other IENs from the Philippines:

> I didn't know about the Filipino nurses association then so all I did was home/read/work/ …… I didn't hear anything from anyone about the exact process – it's like uhh OK this is what I have to do. I have to do this and whatever they want me to do. I did my best….. I got the letter and then I went for bridging program…. it introduced me to the type of nursing we have here in Canada also meeting other Filipino nurses– they were very helpful. [Angelica, RN]

By contrast, Sarah preferred to seek information from the internet and only relied on her Filipino nursing friends to a limited degree. She remarked, "OK so I researched on the internet how to become a RN in Canada and how to become a RN in Alberta. I asked questions of my fellow Filipinos here that are already RNs but mainly what I did was just research on the internet" [Sarah, LPN].

Table 29. Perceived Helpfulness of Pre-Licensure Information and Support – RNs and LPNs

Percentage (%)*	Very Helpful	Quite Helpful	Neutral	Not Very Helpful	Not At All Helpful	None Provided	md
Family	70.1%	11.9%	8.3%	-	1.8%	7.9%	5
Friends	55.4%	22.9%	13.2%	0.65%	1.15%	6.75%	6
Employer	35.4%	19.8%	17.9%	3.0%	4.1%	19.9%	5
Other IENs	44.1%	27.7%	14.4%	1.9%	-	12.1%	12
Nursing Recruitment Officer	22.8%	20.3%	19.4%	3.1%	2.5%	32.3%	8
Preceptor/Mentor	25.9%	27.5%	12.8%	1.8%	1.2%	31.1%	8
Nursing Regulator	28.6%	33.1%	27.0%	1.2%	0.7%	9.5%	5
Philippine Community	23.5%	24.1%	23.5%	4.2%	1.8%	23.0%	6
Nursing Union	11.1%	15.6%	23.0%	1.6%	1.9%	41.7%	7
Government Services	12.7%	17.7%	23.8%	3.1%	3.6%	39.3%	7

Note. *Valid percent: [Total n – md]

Formal supports.

Nursing regulators. A total of 61.7% (valid %: n=167) of participants ranked the information and support received from the nursing regulators as very helpful or quite helpful (see Table 29). Qualitative comments identified the regulators' websites, email communication, and, on occasion, direct contact as the key sources of information. One RN participant remarked, "as soon as I came in 2010 I already took/went to the CRNM website and take a look at the process about how to become an RN here" [Angelica, RN]. Similarly, Sarah, a LPN from Alberta, noted, "It was a very straight forward process, I just contact the LPN College through email and passed my documents there and after 3 months they granted me the permit" [Sarah, LPN].

Likewise, Riza commented:

> So I did some research online then I went to the website – the LPN website – and I even went to their office here in Edmonton and they referred me to the school and told me where I should- need [to go]. [Riza, URHW]

Employers. Employers were identified by 55.2% (valid%: n=167) of participants as quite helpful or very helpful in providing information and support about becoming a nurse in Canada. During the qualitative interviews, only two participants commented on employer support in the pre-licensure stage. Both participants had been recruited to Canada, one to Saskatchewan and the other to Manitoba. One participant, who had been recruited by the Saskatchewan Government, commented on the level of support he had received from his employer upon arrival. He noted that the level of support he received was an improvement over the support provided to earlier recruits and had contributed positively to success on the licensing exam:

> OK we had a really good orientation. We came by batches to the health region. I'm under Prince Albert – Parkland health region – The province of SK recruited 300 nurses in the health region we received 50-60 nurses from that 300. The first batch did not receive any orientation at all and then when they started working as a GN they were just oriented to the floor and after a few months they took the exam and the majority of them failed the exam and retook it and eventually passed. But this time, during the second batch - there were 5 or 6 batches that came - on our batch they oriented us for about 1 month. Theory wise – what is nursing in Canada? What would you expect? The transcultural aspect of nursing cause there is some aboriginal population here. They prepared us for the exam too. They gave us sample questions from the CRNE book. Yes, they prepared us for a month, theory wise in the class room and then in the field they oriented us for 2 weeks hands on and then when it was time for us to take the exam 98% of us passed. [Christopher, RN]

Likewise, Joseph, who had been recruited by a Regional Health Authority in Manitoba, remarked that they had been provided with mentors to help them review for the national licensing exam:

> When we came here we worked first as general nurses, at this time we were preparing for the CRNE, they also provided us with mentors throughout the review process…. If we had some questions with regards to the Canadian Health Care system they would be always there and answer the questions ….Orienting us to the culture of the people here, especially the First Nation's culture. [Joseph, RN]

Nursing recruitment officers. A total of 43.1% (valid %: n=164) of survey respondents ranked the information and support provided by nursing recruitment officers as very helpful

of quite helpful (see Table 29). Joseph, when asked about the RN registration process, remarked, "Well it was actually taken care of by the recruitment officer when we were hired in the Philippines…. What I'm saying is that there were people from PNP [Provincial Nominee Program], people from CRNM, people from the region, they all went there [to the Philippines] to make sure things went smoothly for us" [Joseph, RN]. By contrast, Michelle noted that while she had been given some information on Registration from the recruitment agency, the information provided had been inadequate: "[The] recruiting agency told us what we have to do. But actually it was not fully described what you will be expecting in the information package – it doesn't say the SEC will be like this and there will be a practical – I was not expecting this – but because I was already here I say OK this is how they do it" [Michelle, RN].

Nursing union. Information and supports offered to IENs by the nursing union were identified as very helpful or quite helpful by 26.7% (valid %: n=165) of survey participants. One interview participant described how she really did not know how to proceed with registration when she first arrived. Once she connected with the Manitoba Nurses Union (MNU) however, she was then able to connect with other IENs and obtain support:

> I don't know where to start because when we came here I don't know anyone, I don't know any nurse and we have umm a family friend who is a nurse but she has been a nurse for 40 for 40 plus years and she does not know the process here anymore and she is really up to date on everything with the registration and things like that. So honestly I didn't get any help I just start by reading, passing my application, keeping on calling them but it is just so frustrating at first feeling like you don't get any help. And then I learned about the MNU thank goodness I met some people, some nurses, so MNU helped me a lot. [Hannah, RN]

Bridging education. Bridging education was identified by a number of participants as a helpful source of support during the pre-licensure period. Angelica was initially upset when referred to bridging education but explained that once she was enrolled, she found it helpful. She remarked:

> I went for bridging program which was very, very helpful. I got the referral March and I started August…. Umm at first I was kind of – it shocked me – ohhh I have to do this before I can take the exam – it's like a double screening – like before that I have my friends who took the NCLEX and went to the states and they said they just took the exam and then you can work – but then I can't do that because my family is here – so I just have to take it. Well I would say the process is very helpful for International nurses – especially the bridging program – it is very helpful. [Angelica, RN]

Likewise, when asked about the bridging program Anna had taken, she answered:

> I learned a lot and they helped with a lot. I'm really thankful that I went back to school – it's totally, like the practice is totally different. Yes I was really glad that I took them. Even at the end the exam was much easier for me. Some of my friends who did not take courses – I think some of them failed. [Anna, RN]

Several participants who were currently working as URHWs commented that they would like the option to choose to attend a bridging program, even if the results of the CCA suggested that bridging was not required. Arvin stated:

> I would like to say… Like if you want to enroll, like we can just enroll. Maybe possible if they want us – because most of the IENs are doing a bridging program, why don't they just open some and we can enroll directly. If it is possible, even last year, if I want to take courses I might take courses you know because I want to know everything about the Canadian culture, the health care system, then I might enroll immediately. But the thing is they want us to take the CCA ad then if we pass we can write immediately. But the thing is we also want to study more. [Arvin, URHW]

Similarly, Analyn had limited nursing experience in the Philippines and felt she would benefit from a bridging program. She queried if placing her name on the wait list for a bridging program immediately, rather than waiting for the CCA results, would make the registration process faster:

> Can we - or - for us - I just graduated and I only have one year of experience so are we allowed to just take ourselves to the bridging program and not take the CCA… Cause after you complete your file with CRNM you need to wait 3-4 months now if you just put your name on the waiting list, maybe I would have a spot by then. [Analyn, URHW]

Government services. Amongst survey participants, almost one third (30.4%) indicated that government/immigration counselors had been very helpful or quite helpful in providing pre-licensure information or support. During the qualitative interviews, two participants identified government services were helpful in providing information and access to financial support to assist with the expenses associated with registration. One participant explained that shortly after immigrating to Canada, she had separated from her husband, and as a result lost all her family support. She contacted a career centre and was connected to the government settlement program Manitoba Start. Through Manitoba Start, she was referred to the Winnipeg English Language Assessment and Referral Centre (WELARC) for language assessment and training: "[I was introduced to] a career centre, and they asked me to take the Manitoba start

and Manitoba start referred me to WELARC and from there I took the [English] exam – and they referred me to [an English Language program for IENS]" [Analyn, URHW]. Another participant, from Saskatchewan, discussed a government resource centre that provided information and financial support to Internationally Educated Health Professionals (IEHP). Asked to identify what supports had helped the most, she replied:

> IEHP really helped us a lot. They gave us resources. [We access] it is by the library and they connect us to other members of the IEHP who have been through it. [Researcher: Is it an office you can go to and access supports?] No, we can only go to it online because they are from Saskatoon. It is just a program running until 2016. We apply there and then they talk to us via skype and then we just apply for whatever reimbursements that we have and so they reimburse everything that we have. [Nicole, LPN]

Additional sources of information. During the qualitative interviews, participants who did not have family, friends, or initial connections to the Philippine community in Canada were asked how they accessed information and support regarding the registration process. For these IENs, the internet was identified as the primary source of information or support. When asked how Patricia learned about the Registration process, she responded, "I just do a lot of searching on the internet umm I always spent a lot of my time searching – I don't know anyone moving to MB so basically I just do all the searching myself and just making my eyes wide open and listening to things around. That's how I find about the process" [Patricia, RN]. The Catholic Church was also identified as a source of information and support:

> It was very hard for me, I didn't know anything about it. I had to research on my own, I didn't have any friends that were nurses. The only one who told me were the newcomers – the catholic newcomers in Calgary (church) so I started to do some workshops on resume building and stuff umm yeah – and they gave me the address for the CARNA website and then I researched from then on. [Anna, RN]

Financial supports. Full-time and part-time work was the primary source of financial support for both RN and LPN participants. A total of 45% of RN and LPN participants worked full-time and an additional 13% worked part-time. Financial support from a spouse, parents, or other family members was identified as the primary source for 16% of IENs and personal savings were utilized to finance the registration process for 14% of participants. Only 3% of participants identified government employment insurance as a primary source of financial support, and only 3% utilized bank or government loans and bursaries (see Figure 11).

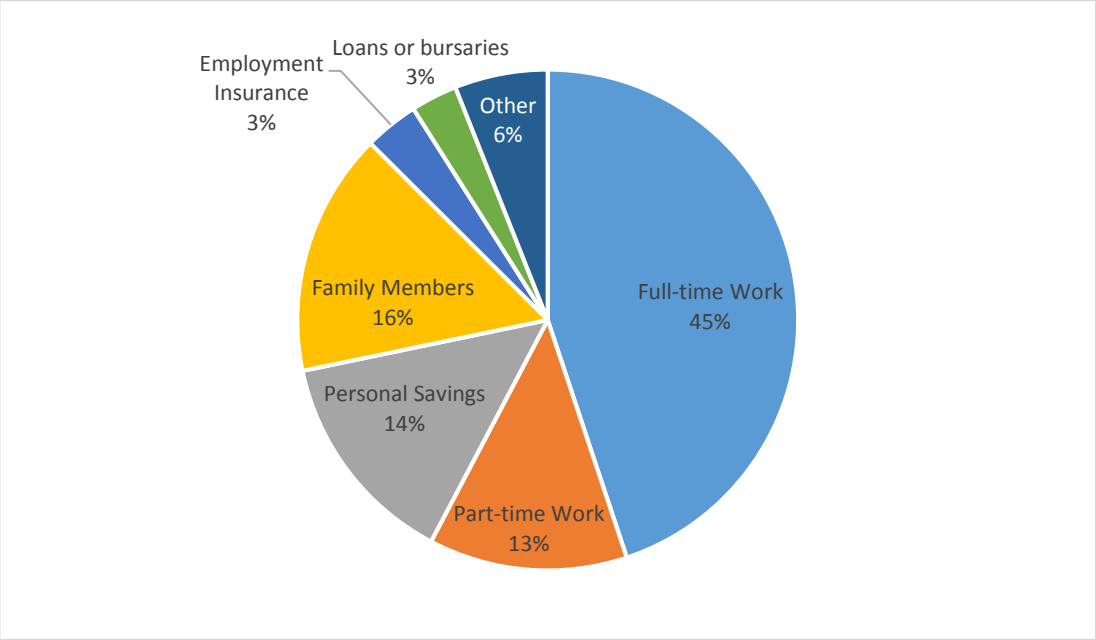

Figure 11. Primary source of financial support for RNs and LPNs – Pre-licensure.

Section Seven: Current Workforce Profile of RN and LPN Participants

Research Objective: Describe the current workforce profile of nurses who have migrated from the Philippines to the Canadian Prairies between 2008 and 2013.

Work force profile in Canada. A total of 82 of the 84 (97.6%) RN participants were employed as RNs in one of the three Prairie Provinces. Of the two remaining RN participants, one was employed as a LPN and the other was employed as both a RN and a LPN. A total of 81 of the LPN participants were employed in the regulated nursing workforce. 78 (88.6%) of the LPN participants were employed as LPNs, one was employed as both a RN and LPN, one was employed as a Graduate Nurse (RN), and another as a RN (see Table 30). The seven remaining LPN participants were unemployed. The results of a Fisher's exact test indicated the unemployment rate of LPNs was statistically significant as compared to RNs, p=.008.

Table 30. Current Employment in a Regulated Nursing Profession

Frequency (%)	RNs	LPNs	Total
A Registered Nurse (RN)	82 (97.6)	1 (1.1)	83 (48.3)
A Licensed Practical Nurse (LPN)	1 (1.2)	78 (88.6)	79 (45.9)
Both a Registered Nurse (RN) and a Licensed Practical Nurse (LPN)	1 (1.2)	1 (1.1)	2 (1.2)
A Graduate Nurse (RN)	-	1 (1.1)	1 (.06)
Not Currently Working as a RN or LPN	-	7 (8.0)	7 (4.1)
Total	**84**	**88**	**172**

Both RN and LPN participants found their first job as a regulated nurse relatively quickly, with 87.8% of IENs from both professions reporting that they were able to secure their first nursing position in less than 6 months (see Table 31). Of the seven LPN participants who were unemployed, five participants indicated that they were seeking employment, but jobs were difficult to find. One LPN wrote, "I am currently applying/looking for an LPN job and waiting to be interviewed and hopefully be hired as an LPN in one of the facilities here in Alberta" [R.V., LPN]. Another remarked that he had "No job offers. Job opportunities are near to hopeless" [Z.H., LPN]. Two participants held a conditional practice permit, as they had not yet written and passed the National Licensure Exam for LPNs. Both felt that the conditional permit was a factor preventing them from finding employment. L.P. wrote, "I have my temporary permit as a conditional registrant. I have tried applying in different settings-- hospital, retirement homes, clinics but none has responded yet. I am writing the CPNRE this Sept, hopefully if I passes, it will change how employers look at me as an LPN. :)" [L.P., LPN]. One of the seven participants indicated that she was not currently seeking employment for family reasons. In her words, there was "nobody to watch 2 kids" [I.M., LPN]. The final participant did not provide a reason for her current employment status. Of the seven participants, five were living in Alberta and two in Saskatchewan.

Table 31. Length of Time to Find First Job as a Nurse in Canada

Frequency (%)	RNs	LPNs	Total
Less than 6 months	74 (88.1%)	77 (87.5%)	151 (87.8%)
6 months to 1 year	6 (7.1%)	3 (3.4%)	9 (5.2%)
More than 1 year	4 (4.8%)	1 (1.1%)	5 (2.9%)
Currently Unemployed		7 (8.0%)	7 (4.1%)
Total	**84**	**88**	**172**

A total of 57% of RN and LPN participants were employed full-time. An additional 26.7% were employed part-time, 9.9% were employed on a casual basis, 1.7% reported that they were currently on a leave of absence from work, and 1.2% of the RN participants were self-employed (see Table 32).

Table 32. Current Employment Status: RNs and LPNs

Frequency (%)	RNs	LPNs	Total
Employed and working full-time	48 (57.1)	50 (56.8)	98 (57.0)
Employed and working part –time	28 (33.3)	18 (20.5)	46 (26.7)
Employed and working casual	5 (6)	12 (13.6)	17 (9.9)
Employed and currently on a leave of absence	2 (2.4)	1 (1.1)	3 (1.7)
Self-employed	1 (1.2)	-	1(0.6)
Unemployed		7 (8)	7 (4)
Total	**84**	**88**	**172**

Approximately one half (53.3%) of RNs and LPNs were satisfied with the number of hours they were scheduled to work; however, 43.6% indicated that they would like to work more hours (see Table 33).

Table 33. Satisfaction with Number of Scheduled Hours of Work: RNs and LPNs

Would you like to work:	RNs	LPNs	Total
Fewer hours	3 (3.6%)	2 (2.5%)	5 (3%)
About the same number of hours	45 (53.6%)	43 (53.1%)	88 (53.3%)
More hours	36 (42.9%)	36 (44.4%)	72 (43.6%)
Total	**84**	**81**	**165**

It is interesting to note that while 64.7% of IENs who were working casual and 47.8% of IENs who were working part time wanted to work more hours, a substantial number (39.8%) of IENs working full-time also indicated a desire to work more hours (see Table 34). Only 3% of all participants indicated that they would like to work fewer hours.

Table 34. Satisfaction with Number of Scheduled Hours of Work by Employment Status

Would you like to work?			
Frequency (%)	Employed Full-time	Employed Part-time	Employed Casual
Fewer hours	4 (4.1)	-	1 (5.9)
About the same number of hours	55 (56.1)	24 (52.2)	5 (29.4)
More hours	39 (39.8)	22 (47.8)	11 (64.7)
Total	**98**	**46**	**17**

A number of participants reported working for two or more employers to obtain their current number of hours. A total of 19.4% of participants working full-time, 45.7% of participants working part-time, and 52.9% of participants working casual reported that they currently worked for two or more employers (see Table 35).

Table 35. Number of Current Employers by Employment Status

Frequency (%)	Employed Full-time	Employed Part-time	Employed Casual
One employer	79 (80.6)	25 (54.3)	8 (47.1)
Two or more employers	19 (19.4)	21 (45.7)	9 (52.9)
Total	**98**	**46**	**17**

The majority (63%) of participants reported that their primary practice setting was acute care. An additional 23.6% of IENs reported that their primary practice setting was a personal care home or assisted living environment. The results of a Chi-square test for independence indicated that RNs were more likely than LPNs to work in an acute care setting, χ^2 (1, n=165) = 12.72, p < .001, phi = -.28. LPNs were more likely than RNs to work in a PCH/Home Health Care setting, χ^2 (1, n=165) = 8.29, p = .004, phi = -.22 (see Table 36).

Table 36. Primary Practice Setting in Canada

Frequency (%)	RNs	LPNs	Total
Acute Care Unit	64 (76.2)	40 (49.4)	104 (63)
Rehabilitation Unit	4 (4.8)	5 (6.2)	9 (5.5)
Chronic Care Unit	2 (2.4)	7 (8.6)	9 (5.5)
Personal Care Home/ Home health care	12 (14.3)	27 (33.3)	39 (23.6)
Community Health	1 (1.1)	1 (1.2)	2 (1.2)
University/College	-	1 (1.2)	1 (0.6)
Other (Not Specified)	1 (1.1)	-	1 (0.6)
Total	**84**	**81**	**165**

A total of 92.7% of participants were currently employed in staff nurse positions. A small number of both RNs (6%) and LPNs (4.9%) indicated that they were in charge nurse or team leader positions (see Table 37).

Table 37. Primary Nursing Position in Canada

Frequency (%)	RNs	LPNs	Total
Staff Nurse	79 (94)	74 (91.4)	153 (92.7)
Charge Nurse / Team Leader	5 (6)	4 (4.9)	9 (5.5)
Educator	-	1 (1.2)	1 (.06)
Other (not specified)	-	2 (2.5)	2 (1.2)
Total	**84**	**81**	**165**

The job turnover rate was low amongst study participants. Approximately three-quarters (75.8%) of both RNs and LPNs indicated that their current employer was their first employer in Canada (see Table 38).

Table 38. Current Employer: 1st Employer as a RN or LPN in Canada

Is your current employer your first employer as a RN/LPN in Canada?			
Frequency (%)	RN	LPN	Total
Yes	60 (71.4)	65 (80.2)	125 (75.8)
No	24 (28.6)	16 (19.8)	40 (24.2)
Total	**84**	**81**	**165**

Of the RN and LPN participants who indicated that their current employer was not their first employer in Canada, 23 of the 40 had worked for one other employer, 14 had worked for two other employers, and only 3 IENs had worked for three or more employers as a RN or LPN in Canada (see Table 39).

Table 39. Number of Other Employers as a RN/LPN in Canada

Frequency	RN	LPN	Total
1	16	7	23
2	6	8	14
3 or more	2	1	3
Total	**24**	**16**	**40**

Amongst survey participants, a total of 56 RNs obtained RN registration in Canada in 2010 or earlier (see Table 40). Of these, 31 (55.4%) indicated that they had worked for their current employer for more than 3 years, and 22 (39.3%) had worked for their current employer for 1-3 years. Only 3 (5.4%) participants had worked for their current employer for less than one year (see Table 41). Likewise, a total of 43 LPN participants obtained LPN Registration in Canada in 2010 or earlier. Of these, 36 (83.7%) indicated that they had worked for their current employer for more than 3 years and 5 (11.6%) had worked for their current employer for 1-3 years. Only 2 (4.7%) participants had worked for their current employer for less than one year.

Table 40. Year of Registration as a RN or LPN in Canada

Frequency (%)	RN*	LPN	Total*
Prior to 2008	2 (2.4)	-	2 (1.2)
2008	2 (2.4)	18 (22.2)	20 (12.2)
2009	40 (48.2)	20 (24.7)	60 (36.6)
2010	12 (14.5)	5 (6.2)	17 (10.4)
2011	6 (7.2)	6 (7.4)	12 (7.3)
2012	13 (15.7)	8 (9.9)	21 (12.8)
2013	8 (9.6)	24 (29.6)	32(19.5)
Md	1	-	1
Total	**84**	**81**	**165**

Note. *valid percent: RN [n=83]; Total [n=164]

Table 41. Length of Time with Current Employer by Year of Registration in Canada

Frequency		< 1 year	1-3 years	> 3 years	md
RNs					
	<2008- 2010	3	22	31	1
	2011- 2013	12	12	-	3
LPNs					
	2008- 2010	2	5	36	1
	2011- 2013	30	7	-	

Intention to Stay in Current Nursing Position. A total of 76 of a possible 84 RNs and 70 of a possible 81 LPNs responded to the survey question regarding their intention to stay in their current nursing position. The majority of RNs who responded intended to stay with their current employer for a number of years. The largest percentage (41%) indicated their intention to stay with their current employer for another 1-5 years. An additional 21% indicated their intention to stay for 6-15 years or "many more years". Notably, 25% of RNs indicated a desire to stay with their current employer for 16 or more years or until retirement. Similarly, amongst the LPNs who responded, the largest percentage (47%) indicated their intention to stay with their current employer for another 1-5 years. An additional 17% indicated a desire to stay for 6-15 years or "many more years," and 20% of LPNs stated they would like to stay with their current employer for 16 or more years or until retirement (see Table 42).

Table 42. Intention to Stay in Current Position

How long do you plan to stay in your current position?		
Frequency (%)	**RNs**	**LPNs**
Less than 1 year	4 (5.3)	9 (12.9)
1-5 years	35 (46.0)	33 (47.1)
6-10 years	7 (9.2)	8 (11.4)
11-15 years	6 (6.6)	1 (1.4)
16-20 years	8 (10.5)	6 (8.6)
More than 20 years	7 (9.2	7 (10.0)
Text Responses		
Until retirement	4 (5.3)	1 (1.4)
Many more years	4 (5.3)	3 (4.3)
Until I find full-time work	-	1 (1.4)
Until I become a RN	-	1 (1.4)
Uncertain	2 (2.6)	-
Md	8	11
Total	**84**	**81**

Perceived match between pre-migration education and work experience and current employment in Canada. IEN participants were asked if they thought their current nursing position was appropriate given their level of knowledge and experience. Responses varied; while some participants felt that their qualifications were a good fit, others felt overqualified. A small number felt under-qualified for their current nursing position. Respondents described the match between their qualifications and their current nursing position either in terms of their status as a RN or LPN or in relation to the setting where they were employed.

Nursing Profession: LPNs. A number of the LPN participants commented that they felt they were overqualified for the LPN profession in Canada. Completion of a four year Baccalaureate degree in nursing, along with prior nursing experience as a RN, were the main reasons cited. One survey participant noted that she was overqualified for her current position

as an LPN "Because of my education and experience back home" [I.J., LPN]. Another noted, "I feel overqualified to be an LPN since I am a registered nurse back home in the Philippines" [V.X., LPN]. Participants described their LPN practice as limited in scope: "I feel overqualified because in the Philippines I worked as an RN and in Canada LPNs have a limited scope of practice" [U.Y., LPN], and felt their pre-migration qualifications prepared them for the "full scope" of practice as an RN. As one interview participant explained:

> there is some – really - limitations when it comes to our functions as LPN compared to when you are RN - there are some skills or some responsibilities that you cannot handle because you are not an RN.... my thing is we were educated as a RN back in the Philippines and your training here is not different from our training. Exactly - we also use the same text books the references are the same. It doesn't differ from what you have here. [Joan, LPN].

Not all LPNs felt over qualified for their current position. Several IENs commented that the LPN role was a good match for their skills. One participant commented, "I feel that my qualifications are a good fit" [R.S., LPN]. Another noted, "I am educated, adequately skilled, and competent" [Q.U., LPN]. Still another remarked that the LPN profession provided an opportunity to resume her nursing career in Canada: " I have had worked in an acute care more than 10 years in the past, with excellent experiences, skills and knowledge learned as nurse .... I'm proud working being in a assisted living facility with the elderlies, this is a fullfilment of my career as a caring nurse" [N.L., LPN]. A number of nurses noted that the LPN role provided an entry point into nursing practice in Canada. One survey participant, with limited pre-migration experience as a nurse, commented, "I only had less than 6 months of experience as RN in the Philippines. So being a LPN here is like a refresher or a preparation for being a RN in the future" [H.P., LPN].

While several participants felt that their qualifications were a good match for the LPN role in Canada, a few acknowledged that this did not preclude the need to learn about nursing practice in Canada. This sentiment is encapsulated in the comments of the following participant. She described feeling qualified, in fact overqualified, for an entry level LPN position yet recognized she had things to learn. Responding to the question 'are your qualifications suitable for your current nursing position,' she wrote:

> Yes and No. Yes I feel overqualified because I was a Charge Nurse in the Philippines and then I went into Nursing Education-was a Clinical Instructor and then became a Clinical Coordinator so I feel I am more qualified to start at an entry level. No because I have still things to learn [Z.D., LPN]

Nursing profession – RNs. The majority of comments provided by the RN participants indicated that they felt their current position as a RN was a good match for their qualifications. One participant stated, "I do think i am qualified because [I] can provide the nursing care that my patient can expect" [C.J., RN]. Another noted, "With my previous experience working at acute care, I would say I am fit to work at my present job as not only the RN but the only nurse assigned for the building which consist of three floors" [E.O., RN]. One participant commented that her current position as a RN was a better match for her qualifications than her previous position as a LPN. She wrote, "I believe my current nursing position is appropriate, when I am still an LPN, I think I am overqualified because I am an RN in the Philippines, but since I strive hard to be an RN too here in Canada, I feel am a good fit for the position as an RN because I can practice it now here in Canada" [B.J., RN].

Noting the difference in nursing practice in Canada as compared to the Philippines, a number of RNs commented on the benefits of bridging education and preceptorship in preparing them for their current nursing positions. One participant noted that her qualifications were "[A] Good fit as the bridging course had given enough information on the issues that will happen in the Canadian Health Care setting" [H.R., RN]. Another wrote, "I feel fit for the position after all the preceptorial trainings that I got in Canada as our nursing practice back home is very different from Canada" [T.B., RN]. On the other hand, one participant, who did not attend a bridging program, described how his initial beliefs about his qualifications were challenged once confronted with the differences in nursing practice in Canada. He remarked:

> I gained knowledge and experience over the years from working since 2009 in Canada on different wards and later to Operating Room. / I thought I was equally qualified to do the job but had a very difficult time adapting to the work/job, environment, people, life in Canada in general. / There was no real orientation that was tailored to IENs. / At present, I believe that I am fit to do my job. [R.Y., RN]

Finally, a few participants who worked in specialty areas (eg. Intensive Care Unit (ICU), the Operating Room (OR), or Dialysis) remarked that the combination of pre-migration entry level nursing education as well as specialty training obtained in Canada provided the necessary qualifications for their current nursing position. In the words of one participant:

> The training that I received from the University of Santo Tomas in the Philippines has prepared me well enough in the feld of nursing. The high standards of training and education from my university, compounded with the critical care training I received here in Canada enabled me to be a competent, compassionate and confident as an ICU nurse. [K.Q., LPN]

Practice setting – LPNs and RNs. Both RN and LPN participants commented on the suitability of their qualifications in relation to the practice setting where they were employed. As the following comments demonstrate, nurses who felt they could fully utilize their knowledge and skills felt there was a good match between their education, work experience, and current employment. One LPN participant remarked, "My qualifications really fit to my position because as LPN in dialysis unit we have a full scope job" [T.U., LPN]. Another LPN noted that her qualifications were a good fit, "Since LPNs are in charge of the floor, my clinical judgment is being developed and as well as managerial skills" [W.U., LPN]. Similar comments were expressed by a number of RNs. As one RN nurse wrote:

> I am happy with the work I am doing and with the employer I am working for. I am working as an Operating Room Nurse in a Trauma hospital and the work is exciting and satisfying. There is a healthy work environment where everybody feels needed and appreciated for the work they do as a member of the healthcare team. There is help/resource available if I feel unsure about my capability to do a certain job and there are courses available to improve or update my skills. My knowledge, experience and qualification is appropriate for the position. [W.D., RN]

Other participants noted that their qualifications were a good match because their current employment setting was similar to their pre-migration employment. In the words of one RN, "I am currently employed as an obstetrical nurse where I have accumulated more than 20 years of experience from the institutions I've worked for from the Philippines, the Middle East and here in Canada" [A.J., RN].

Some IENs felt qualified for their current practice setting; however, they noted that they would not or did not feel comfortable in another. For example, one LPN wrote, "I know I am confident when working in long term care. With acute care setting, I think I need refresher course" [G.E., LPN]. Similarly, a RN participant commented, "I used to work in Surgical and obstetrics ward before I got the job in Long term Care. I just feel stressed and often under staff in an acute setting. Since I'm getting the same salary I will stay in non-acute setting for now. I think my qualifications for my present job now is just appropriate" [G.Q., RN]. Conversely, one participant remarked that while she felt underqualified for her current nursing position, she believed if she worked in a familiar practice setting, she would feel differently. She wrote, "At first, even after orientation, I still feel underqualified since I am new and it is s specialized field which I have never worked before. If I was working in an area where I used to work before, I think the feeling will be opposite" [P.N., LPN].

Finally, a small number of participants felt overqualified for their current nursing position. It is important to note that all of the IENs who expressed this sentiment worked in a long term

care setting. One participant who had acute care experience in the Philippines remarked, "I've worked as an RN for 2-3years in an acute setting. The skills and knowledge I know is slipping away because I don't apply it in a Nursing home" [M.K., LPN]. Another who recently moved from a long term care to acute care setting stated, "I just moved from a personal care home to an acute settings about a year ago. I think my nursing position now is appropriate" [E.A., RN].

Section Eight: Integrating into the Regulated Nursing Workforce in Canada: Post-employment Challenges

Research Objective: Describe the challenges nurses from the Philippines encountered while integrating into the Western Canadian nursing workforce?

Adjusting to nursing practice in Canada. RN and LPN participants described a number of challenges they encountered integrating into the nursing workforce in Canada. The main challenges fell into five main categories: language and sociocultural communication, knowledge and skills, adjusting to different resources, conflicting values, and professional and collaborative practice.

Language and sociocultural communication. A total of 10 survey questions that focused on language and sociocultural integration were included in the data analysis. The questions explored English language skills, therapeutic communication, assertive communication, and delegation skills.

English language skills. A small percentage of both RN and LPN participants identified communicating in English at work as a challenge. Only 3.6% of RNs and 7.5% of LPNs indicated that they agreed or strongly agreed that they found it difficult to communicate in English. However, a larger percentage of RNs (31.3%) and LPNs (32.6%) indicated that they strongly agreed or agreed that the different accents encountered in the work setting were difficult to understand (see Table 43).

Table 43. Perceived Difficulty with English Language Skills in Work Setting

Frequency (%)	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**md**
Registered Nurses						
I find it difficult to communicate in English	27 (32.5)	43 (51.8)	10 (12)	2 (2.4)	1 (1.2)	1
The different accents are difficult to understand	6 (7.2)	26 (31.3)	25 (301)	25 (30.1)	1 (1.2)	1
Licensed Practical Nurses						
I find it difficult to communicate in English	27 (33.8)	41 (51.3)	6 (7.5)	6 (7.5)	--	1
The different accents are difficult to understand	12 (15.0)	22 (27.5)	20 (25)	25 (31.3)	1 (1.3)	1

The comments provided during the telephone interviews supported the survey finding that communicating in English within the work environment was not a significant challenge for participants. As one participant noted, the high English language scores required to enter the profession ensured an adequate level of English language skill for practice. When asked if he had encountered any challenges speaking English in the work environment, he responded:

> For me personally I did not encounter a real problem with that. In working in the Middle East before I came here our medium of language would be English plus we were required to take the IELTS exam before coming here – we had to be IELTS passers. So I think the English of it is not that difficult. [Joseph, RN]

While communicating in English was not perceived as difficult, several participants noted that working in a multicultural environment and understanding different accents was challenging at times. Grace remarked, "Umm with the patients I didn't find it hard to talk to them at all. Or with my nursing colleagues. Some of the staff, actually especially from East Indian races their accent is so heavy, but as you work with them you get used to how they

speak so it's OK it's all a matter of adjusting to everyone" [Grace, RN]. Similarly, Maria described, with humour, an exchange with a foreign trained physician and how both her accent and the physician's impeded communication. She commented, "I even had an Indian Doctor she had a strong accent and she said I am having trouble understanding you because of your strong accent – and I was laughing because she also had a strong accent" [Maria, LPN].

Communicating with patients and families. Only a small percentage of survey participants indicated that communicating with patients and families was difficult. Amongst participants, 4.8% of RNs and 10% of LPNs agreed or strongly agreed that communication with patients was difficult, and 6.1% of RNs and 13.8% of LPNs agreed that communication with families was difficult (see Table 44).

Table 44. Perceived Difficulty with Therapeutic Communication

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**md**
Registered Nurses						
Therapeutic communication with patients is difficult	15 (18.1)	48 (57.8)	16 (19.3)	3 (3.6)	1 (1.2)	1
Therapeutic communication with families is difficult *	14 (17.1)	44 (53.7)	17 (20.7)	5 (6.1)	-	2
Licensed Practical Nurses						
Therapeutic communication with patients is difficult	16 (20)	40 (50)	16 (20)	8 (10)	-	1
Therapeutic communication with families is difficult	14 (17.5)	38 (47.5)	17 (21.3)	11 (13.8)	-	1

Note. *Two RN participants answered "Don't Know"

Communication with patients and families was further explored during the qualitative interviews. In contrast to the survey responses, participants described a number of challenges encountered, especially in regard to the sociocultural aspects of communication, while

working with patients and families. For example, participants noted that understanding idioms as well as how to address patients and families in a culturally respectful manner took time. Christopher described the challenges he encountered. Even though he had studied English since Kindergarten, knowing and understanding Canadian expressions had to be learned:

> I have learned - and the majority of the Filipino nurses have learned English since kindergarten umm we didn't use English as a daily communication tool. It's used in school and it's used in business – like if you go to the Philippines everything is written in English but we didn't use it as a daily conversation tool we used our native tongue to communicate so coming here first it was the communication and then part of the communication is that they used lots of idiomatic expressions umm other vernacular terms and there were lots of terms we needed to learn before for example, a walk in the park we took it literally, like what do you mean a walk in the park. It took us time. [Christopher, RN].

Participants also expressed concern that they might inadvertently offend a patient or family member by using an incorrect term or expression. As Joan commented, "Like we Filipinos we usually address our elders as grandmother, grandma, grandpa like we don't mean anything with that it is some kind of respect but if you use it here they will be offended, just like those simple things. Yeah it is very hard to adjust" [Joan, LPN]. Similarly, Hannah described her concerns, "like you know the culture for instance, for I may say something that is culturally not acceptable here. It scares me because I might say something that might offend someone or they might think I'm disrespectful" [Hannah, RN].

Bea described the challenge of communicating with a patient or family from a different culture. Having worked in both Canada and the Middle East, she notes that it was easier to communicate in the Philippines where there was a shared culture and language between herself and her patients:

> umm I think here in Western countries the patient them self is more involved like with their care that is what I observe. And you know I also work in the Philippines and we practice the same - the way but we communicate in the same language so we can easily understand each other, what we want to tell them, if we want to talk to the family about their loved ones its easier, but here in Canada for me I have to explain things or explain what's going on in a way like according to the policy – things like that I cannot just discuss anything - or in the middle east - its' really hard to elaborate things when it comes to the nursing part because we are trying not to say thing that is not right - we cannot ensure that our communication is like an Arabic speaking person could explain to them. I think in every part of the world that I work it's the communication that is important for you to reach out to your clients or with your patients. [Bea, RN]

Increased involvement of patients and their families in health care decisions was also identified as an initial challenge to communication. As Anna explained, "one of the things

that I needed to learn was interaction with patients. In Canada the practice is about the patient - and family is involved in their care. In the Philippines it's a little like that but it's more the doctors say what needs to be done. And here everybody decides" [Anna, RN]. Likewise, Flora described the cultural differences in nurse/patient communication that she had observed working as an URHW. She highlighted that in the Philippines the nurse was often viewed as the authority and patients had very little input into decisions regarding their treatment or care:

> It is different, it's really different from back home. Because back home we only look into one culture… here the therapeutic communication is very important. Back home it isn't important. The approach is very different. Back home if you're in the nursing profession or in the medical profession you are always the authority. You have to do this, you have to do this, we don't give leeway to the client – It's just limited options for the client. Either you have to follow this or sorry – if you don't follow what the nurses say or the doctors say the client is really a loss. But here the client has the right – the rights are clearly – here the client says I need this and you as the health worker – health professional – we go along with the client – the needs of the client. [Flora, URHW]

Understanding the cultural aspect of patient and family communication took time. As Nicole noted, "The Canadian culture … I am still in the process of figuring it out - but I think in the day to day encounter I understand it bit by bit but I am still not completely comfortable, I cannot say that I know them 100%, The lesser the talk sometimes the better" [Nicole, LPN]. Observing and consulting with colleagues also helped. Bea remarked, "the thing that I did was I mingle most of the time with my coworkers and ask them and consult them if there is a thing that concerns about to how explain to my patient about something… I always observe how they are doing it and from there I saw that I am competent in doing those things" [Bea, RN].

Communicating with health professionals. The ease of communicating assertively with other members of the health care team was examined though a series of four questions on the online survey. Overall, both RN and LPN participants indicated that communicating with other health professionals did not present a significant challenge. Amongst participants, 10.8% of RNs and 6.3% of LPNs agreed or strongly agreed that communicating in an assertive manner with physicians was difficult, 2.4% of RNs and 2.6% of LPNs agreed or strongly agreed that communicating with other nurses was difficult, 4.8% of RNs and 16.8% of LPNs agreed or strongly agreed that communicating with members of the interdisciplinary team was difficult, and finally, 4.8% of RNs and 5% of LPNs agreed or strongly agreed that communicating assertively with support staff was difficult (see Table 45).

Table 45. Perceived Difficulty with Assertive Communication

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know	Md
RNs							
Assertive communication with Doctors is difficult	12 (14.5)	34 (41)	16 (19.3)	12 (14.5)	8 (9.6)	1 (1.2)	1
Assertive communication with other nurses is difficult	10 (12.2)	35 (42.7)	21 (25.6)	14 (17.1)	1 (1.2)	1 (1.2)	2
Assertive communication with the Interdisciplinary team is difficult	12 (14.5)	39 (47)	21 (25.3)	7 (8.4)	3 (3.6)	1 (1.2)	1
Assertive communication with support staff is difficult	12 (14.5)	45 (54.2)	13 (15.7)	9 (10.8)	4 (4.8)	-	1
LPNs							
Assertive communication with Doctors is difficult	9 (11.4)	39 (49.4)	15 (19.0)	11 (13.9)	2 (2.5)	3 (3.8)	2
Assertive communication with other nurses is difficult	8 (10)	38 (47.5)	20 (25)	12 (15)	1 (1.3)	1 (1.3)	1
Assertive communication with the Interdisciplinary team is difficult	7 (8.8)	37 (46.3)	19 (23.8)	13 (16.3)	1 (1.3)	3 (3.8)	1
Assertive communication with support staff is difficult	7 (8.8)	47 (58.8)	14 (17.5)	8 (10)	2 (2.5)	2 (2.5)	1

A few of the responses from participants during the qualitative interviews supported the survey data. For example, Victoria described being more comfortable with Canadian culture than with Filipino culture and enjoyed having the opportunity to express herself freely:

> In the Philippines umm based on my experience we are kind of shy to express ourselves – although I excuse myself - but you know the Filipinos are really shy - most of us are scared to speak out - while here you can speak whatever you want - you can say what you feel. For example, in unit meetings our supervisor from the Philippines would ask questions - we were kind of reserved in speaking out because even though they won't accept it they will hold it against you. Whereas here you can always express yourself – which I really like. Yeah I guess I belong here in Canada, not in the Philippines. [Victoria, LPN].

However, not all participants found assertive communication easy, especially in the initial stages of employment as a nurse in Canada. As Anna remarked:

> For me the first 3 months was very, very stressful for me I didn't sleep before I went to work – I'd be thinking about what would happen. I'm very shy and timid and in my head the language barrier was very difficult – very challenging. I knew I could communicate in English well enough but I'm not that outgoing like I tend to hold back my ideas and it really took me time to express it like umm what I think should be done – It was more being assertive. [Anna, RN]

Similarly, Hannah explained how she was the target of some teasing from colleagues for being "too polite" when speaking with Physicians:

> it's really hard because I cannot assert myself – I can say how I feel but it is not the same way how Canadians really are – they say what they want – they are very assertive. Yeah I'm still very timid. I don't think with patients – more with colleagues. Doctors more - because some of my colleagues say I'm too polite - I just say 'please Doctor' and 'yes Doctor' - just like that because that is the way I used to work back home. I think they said I am too polite they say – 'o you sucker' [laughs]... but that is the way I talk. [Hannah, RN]

Delegating tasks to other nurses and support staff was also perceived to be difficult for some survey participants. A total of 28.1% of RNs and 15.2% of LPNs disagreed or strongly disagreed that delegating to other nurses was easy, and 21.7% of RNs and 18.2% of LPNs disagreed or strongly disagreed that delegating to support staff was easy (see Table 46).

Table 46. Perceived Difficulty with Delegation

Frequency (%)	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**Don't Know**	**Md**
RNs							
Delegating tasks to other nurses is easy	5 (6.1)	18 (22.0)	21 (25.6)	29 (35.4)	8 (9.8)	1 (1.2)	2
Delegating tasks to support staff is easy	3 (3.6)	15 (18.1)	22 (26.5)	32 (38.6)	10 (12.0)	1 (1.2)	1
LPNs							
Delegating tasks to other nurses is easy	-	12 (15.2)	31 (39.2)	27 (34.2)	7 (8.9)	2 (2.5)	2
Delegating tasks to support staff is easy	-	14 (18.2)	27 (35.1)	24 (31.2)	9 (11.7)	3 (3.9)	4

Likewise, delegating to other health professionals was identified as a challenge by several participants during the qualitative interviews. One participant commented, "I know you know Filipino nurses cannot delegate things to other people – I'm still adjusting to that- but I cannot ask people to do that for me … I don't want people to feel I'm bossy – that's how I feel, maybe it's just me personally" [Nicole, LPN].

While difficulties with delegation were identified initially as a challenge, many participants discussed how they had learned to delegate. Joan described a situation that occurred on the psychiatric unit, and how she had to stand up to a URHW who had been upset when a task was delegated to him:

> here its Ok for the patient to go out for a smoke and we have one patient who has to go out accompanied by staff and during the time there was only two nurses on the floor, the charge nurse and me and two psych aides and they have their schedule and this patient wanted to go out and so I asked this psych aide if he would go out with the patient and he did go out but when he came back you know he was murmering things and I asked him and he wasn't happy that I asked him to go with the patient.. So like I am a nurse, and you are a psych aide, not that I'm looking down on your position as a psych aide or belittle your position it wasn't that but as a nurse I can delegate things - give you some obligations on the unit - but to him he wasn't happy -so I told him that I am a nurse and I do have to delegate some tasks. [Joan, LPN]

Likewise Victoria initially struggled with delegation until she learned to "stand her ground" in order to gain the respect of an experienced URHW. She explained:

> Actually at first I had an experience, I had a hard time delegating. I was delegating to a HCA who has been working more years, longer than I did, that's where I think they're trying to challenge the new nurses but I stood my ground – I just challenged do you want to take my responsibilities and I will take yours – I just challenged her – I had to – it's always patient safety first. [I told her]'Before you are getting all those trays there you have to stay here with the patient because she might fall'. They know I speak and then they don't try anymore. [Victoria, LPN]

Jeffrey also described the initial challenges he encountered delegating tasks to experienced URHWs at the first facility he worked as a LPN. Learning from this experience, when he started a new job, he approached things differently. He took the time to get to know his colleagues and was able to earn their respect:

> I'm just kind of shy and we have this HCA whose been there for about 20 years and it seems like they have what we call seniority complex they've been working there and they are the HCA and you are the new one and it is like they are bullying you and if you delegate to them and they answer you in an unrespectful manner so of course - I just do it. So I have just experienced that before and they actually don't follow you. Well you know what, for me I actually, I started in a new job. I always observe, be nice to them, mingle with them and I can get their respect and then we end up getting on together – and we helped each other….If you respect them, they will learn to respect you too in return. [Jeffrey, LPN].

Finally, Anna talked about how things improved once she learned to delegate things, and felt that patient safety was improved as she was not trying to do everything on her own. When asked about delegation, she responded, "I'm OK with that now. At first I wouldn't want to ask for help from my coworkers. We Filipinos we don't ask for help – we just do it ourselves, no complaining, just go home. So I found it is much better to delegate things. Much safer too. But it took time" [Anna, RN].

Knowledge and skills. Participants commented on the nursing education they had completed in the Philippines and the degree to which it had prepared them for nursing in Canada. Participants emphasized that nursing programs in the Philippines were based on a US curriculum and therefore contained similar content and theory to US programs. As Patricia noted, "back home we are also using the same books on the curriculum – it's basically based on American curriculum so all the books are coming from the US publishers" [Patricia, RN].

Anna observed, "my education was really good, I studied in a really good school and I had my Master's degree as well so I think I was pretty prepared theory wise" [Anna, RN].

While participants felt they possessed a sound knowledge base in many areas of nursing theory, several participants commented that their education in the Philippines had placed less emphasis on the concepts of health assessment and gerontology. When Nicole was asked if the nursing education she had taken in the Philippines prepared her for practice in Canada, she explained, "I would say that in the Philippines we don't have long term care we don't have geriatric there and we don't have care homes…There is really a lot to learn" [Nicole, LPN]. Hannah identified a knowledge and skill gap in the area of health assessment: "Health assessment – there is a little bit of struggle there" [Hannah, RN]. She continued that she would have benefited from taking a health assessment course in a bridging program: "Yes, yes that's the reason why I don't think it's a plus for me that I didn't go to a bridging program. Yes, I would want health assessment really – the Physical exam – it's not that hard but I still want that part" [Hannah, RN]. Finally, Sarah noted that while her nursing education program had provided the necessary nursing theory, there had been a limited opportunity to practice nursing skills in the clinical setting:

> I believe we have the knowledge [but] in the real setting, the practical setting, we haven't encountered that yet because the skills are more advanced here than in the Philippines – what we've learned, the skills we learned in nursing school we haven't applied it that much because the setting is not ideal…it doesn't provide the necessary skills, but RNs here are able to practice in the field the skills they were taught when they were in nursing school" [Sarah, LPN].

Participants also described working with different medications. In some cases, the medications were unfamiliar. In others, it was simply that the names used for medications in Canada were different than the names used for the same medications in the Philippines. For example, Sarah, describing how nursing practice in Canada differed from the Philippines, explained:

> Well um of course the medications, there are a lot of medications that I am studying here, in the Philippines umm there is not much. I haven't experienced a variety of, you know, medications because I only worked in a public hospital [in the Philippines] – it's 100 bed capacity but it's not a tertiary hospital, so it's not that much complicated. I find the medications here challenging – of course I've encountered them during nursing school but some of the medications are new. [Sarah, LPN]

And Jeffrey remarked, "There are actually some medications that are similar but are different in brand name and there are some medication like Oxycodone that I have never heard before. There are a lot of medications like that" [Jeffrey, LPN].

Participants reported how medication administration was often different in Canada versus the Philippines. Victoria commented on how she needed to adapt to the medication dispensing system PYXIS: "with the new machines, like with PYXIS and all those things, I have to adapt to it but after a while I get used to it" [Victoria, LPN]. Sarah explained how she was unfamiliar with the administration of medication through a PEG tube: "I'd never given medications through a PEG tube, right, like in my nursing career, there's no peg tube in the Philippines, I haven't encountered the PEG tube" [Sarah, LPN].

Finally, Pearl described strict medication protocols that need to be followed when drawing up and administering medications in Canada. She noted:

> The medication system as well, there are lots of protocols compared to back home. They are more strict and certain medication protocols. [Researcher: Can you give me an example?] Umm heparin – we do lots of heparin infusion here, where back home I haven't really encountered the heparin infusion and since it's a high alert drug umm they always they have a certain protocol which is good. For me it's very beneficial because I've learned so much from it. Morphine infusion as well, we do it back home, but it's not usual there. [Pearl, LPN]

Conflicting Values. During the telephone interviews, participants discussed the challenge of working in a health care system that espoused different, and at times, conflicting values to their own. Participants identified differences in the approach to pain management, palliative care, elder care, and the nurses' sense of duty as the main areas where values differed.

Pain management. Participants commented on the different approach to pain management in Canada as compared to the Philippines. The priority placed on pain assessment, the attention to the patient's subjective interpretation of pain, and the frequent administration of narcotic analgesics to treat pain were all cited as differences. Participants expressed concern that narcotics were administered too liberally and could lead to patient addiction. They also cited cultural differences in pain tolerance and the approach to pain management as areas of practice that they needed to adapt. One participant commented:

> That's one thing here in Canada, they always focus on pain. They need to address the pain itself. That's one of those factors that I really need to adjust to. There are several pain meds that I can actually give. At home we try to maximize the pain tolerance of the patient. We don't usually give anything unless the pain score is really high. But here, with a rate of 2 or 3 or 4 we give pain meds. I am really quite surprised because

> we can do other stuff other than give those meds and the patient will be too dependent on those, that's what I'm thinking. [Edward, LPN]

Christopher described similar concerns regarding the approach to pain management in Canada. He explained how initially he had even tried to use the same approach to pain management that he had previously used in the Philippines, but it was met with resistance from his patients:

> I've learned when I'm working for 5 years now. Pain wise I've learned that nobody has the right to have to have pain – umm, culturally in the Philippines most people are stoic. They keep the pain and they just hide their pain and tolerate their pain - but here, even a scratch or something, it's like pain. So there is a different pain approach. So initially we were kind of taken aback like 'Oh you give morphine right away'. In my four years of nursing plus my year and a half working in the field so 51/2 years in the Philippines exposed to nursing I haven't given a narcotic once, but here you give it like a candy – to everyone. So there is a different kind of approach to pain management – we were shocked. Why not try the first line of pain management like NSAIDS before we go further - but no, here it is different. And then I tried that myself let me see if I can try the Filipino approach but the patient them self says no it doesn't work, I want this, there is a different cultural shock with regards to pain mgt. [Christopher, RN]

Angelica expressed her initial concerns regarding the amount of narcotic analgesics patients were receiving, but noted that the education she had received from the pain specialist and oncologist helped her make good clinical decisions and alleviated her sense of unease with the pharmacological treatment of pain. She explained:

> It is different back home, people are so afraid for the patient to get addiction and stuff like that. So when I started to work in surgery part of me know that the patient has had this surgery and the amount of pain at the back of your mind – 'Oh you say to yourself – he's too old, maybe he's comfortable, I'm not going to give him a pain killer at a certain hour'. Then we have a pain nurse who educates us – what this patient needs – It's their own pain – they can have it – we have Dr. [H] umm tell us the all the parameters – if they are over dosing, if they are getting too drowsy so it's helped me to uh, to decide by myself when to care – when it is needed and when it is enough. [Angelica, RN]

*Palliative and elder care***.** Participants also expressed conflicting beliefs about palliative care. Joan discussed the moral dilemma she faced caring for clients at the end of life. She described how she felt the nursing care she was required to deliver conflicted with her religious beliefs and values:

> Well for me I just do the best that I can – I try to learn their ways - if it is easy for me to do that, or I can just do that without offending or violating my own principles my own values, I would do their thing, but if not I would do it the way I wanted.

> [Researcher: Can you give me an example] Palliative, particularly in palliative care, umm if [in Canada] a person is in pain, a dying pain, it is just an ordinary thing to give them a pain reliever. Because we are not so used to that, umm maybe our religion, or it's just, why would you give him that, he is dying - like how sure are you that the person is in pain, like you know let him die, let him face his creator sober, awake, not being drugged. Because he would be moaning in bed but you do not really know if he is having pain. If you keep giving the pain reliever he will be drugged you know. [Joan, LPN]

Similarly, Hannah spoke of conflicting values and the moral struggle she felt caring for a client who was receiving comfort care at the end of life:

> Until right now it's still so hard for me to accept when the resident is comfort care already – Palliative care – I think, oh I wish I could do something to make her life longer, but they say it doesn't work that way, you know you have to make them comfortable – things like that - so no heroic measures – you don't send to the hospital. Now it's getting better but at first it was just so hard for me because I think - that's the hardest part, what is the care plan, what does the patient and family want it to be – comfort care, and then you have to respect it. Yeah, so and they asked me before about what I think about comfort care and I said I am a Filipino and we have a very different view about life and if we can extend life even just for a day, umm we try to, so I think it's cultural – it's a cultural issue that I'm struggling with since I've started. We respect that, we provide the care that the resident needs, we make them comfortable, we support the family, it's just hard. [Hannah, RN]

Finally, another participant, working in a personal care home setting, spoke of the different approach to elder care in Canada as compared to the Philippines. Caring for elders in a long term care facility, as opposed to at home with family, was difficult for her to adjust to. While she understood that families had other responsibilities, she worried that some seniors were lonely:

> I started working in the long term care, but in - I don't know, sometimes, I just find it hard because cultural, in our society, in our country, we take care of our elderly at home and not in facilities. Although I see families that are, you know, every day come to visit their loved one in the nursing home, but some are lonely. Yeah, there are no family members visiting them. In trusted totally to their care by other persons. I understand, I tend to adapt also. It is also reasonable for some families because they are busy, the children are busy already with their own families. [Christina, LPN]

Sense of duty. A number of participants voiced differences in the sense of duty they felt as nurses from the Philippines as compared to Canadian nurses. This was most evident in examples provided regarding handover at the change of shift. While participants expressed a sense of responsibility or duty to stay until all their work was completed, they noted, at times

with some disdain, that Canadian nurses left at the end of their shift, passing unfinished tasks to the oncoming nurses:

> Now I even overstay at work without calling it overtime. Because it is our culture to finish what you start – we don't have the heart to just leave it. I'm not blaming some other cultures – but with them it is 7:30 they are done. They would leave even without someone else to endorse their work. We overstay – even if it's not part of our job – for compassion. [Maria, LPN]

Hannah conveyed similar concerns. She was reluctant to leave work undone or to hand work over to the oncoming shift. For Hannah, she was willing to continue with her current practice as she believed it was appreciated by her patients and their families:

> I'm so embarrassed if I leave something for the next shift. For me when I'm working it's like - I didn't do anything - but I know, I did lots already, but I don't feel like going home – especially when it's my weekend off, I don't like to leave things undone…. I work 7:15 to 3:30 but most of the time I go home later – 4:00. it's just too hard for me, they say can you do this - do this – It's just so hard for me until this time… but the one thing that I really, really appreciate most is that the family knows how we were working. Yeah I think they really appreciate what you are doing – I think that is the most rewarding even if you don't expect managers or other nurses to know what I'm doing, but as long as the families and the residents are happy with what I'm doing, I think I'm OK with it. [Hannah, RN]

Not all participants felt conflicted, however. Nicole felt more comfortable working in a Canadian setting with defined shifts, assigned breaks, and clear expectations regarding handover:

> I think I'm comfortable working the Canadian context. When it comes to scheduling they are very time orientated – with their time. In the Philippines, if you are not done you should stay and finish all your work regardless of being paid or not, it is your duty….But here everyone is very orientated to their time and when their time is over they leave their work… I am OK with the change because it makes –it's more clear and the attitude of the next nurses – they are expecting that some stuff will be handed to them if they are next on the shift. But in the Philippines you must finish what you've started. Even though it's your time, if you're not done then ethically speaking you should finish it. Even in my settings and hospitals I've been in, [a] break is not considered a break. If you go for break and you have so much to do, that will become an issue. Here we are really forced to take our breaks [laughs]. [Nicole, LPN]

Working with different resources. Interview participants described the challenge of working with different resources. Different medications, supplies, and technologies, as well as differences in staffing ratios were amongst the most frequently cited.

Physical resources: Supplies and technologies. Participants spoke about the differences in equipment and supplies. Commenting on the differences and similarities in nursing practice between Canada and the Philippines, Isaak stated:

> Well the nursing process would be mostly the same – like procedure wise and I would say the only thing – working in a 3rd world country - and lots of the machines here I never used before, and everyone here uses an IV pump here and back home we used gravity. Yeah, like so equipment wise... Equipment and certain procedures. Even like basic – the brand of dressing. [Isaak, LPN]

Likewise, Grace commented, "Well first of all the equipment, the tools that I need to use in the hospital like a simple suction that I had to set up I needed someone to teach me how to do that. The oxygen - there are a lot of tools or equipment that I need to learn" [Grace, RN].

IENs also discussed how they had been introduced to certain skills and equipment in their nursing education programs in the Philippines; however, the lack of availability of the required equipment in the clinical practice setting meant that they had no opportunity to gain practical experience. As Sarah explained:

> I believe we have the knowledge [but] in the real setting, the practical setting, we haven't encountered that yet because the skills are more advanced here than in the Philippines – what we've learned, the skills we learned in nursing school we haven't applied it that much because the setting is not ideal, [the hospital in the Philippines] doesn't provide the necessary skills but RNs here are able to practice in the field the skills they were taught when they were in nursing school. [Sarah, LPN]

It is important to note that although the majority of IENs spoke of having limited access to certain supplies and technologies in their nursing practice pre-migration to Canada, this was not the experience of all participants. Vince, who had worked in a large, accredited facility in the Philippines, noted that "back in the Philippines we were using more advanced technology" [Vince, LPN]. And Bea who had worked in the Middle East before coming to Canada remarked "umm in Qatar, I think when I was there it's more advanced" [Bea, RN].

Human resources: Nurse to patient ratio. Participants commented on the improved nurse to patient ratio in Canada as compared to the Philippines. Maria explained the challenges and skills required to practice nursing in a setting with limited human resources. For Maria, working in Canada was less stressful:

> In the Philippines we were understaffed – when I was working as a nurse the ratio was one nurse to 48 clients. Because it is a general ward I have surgery, OB, medicine – the only thing I don't have is Psych. The transfer of one kind of sickness would be

> easy to transfer to another client. With those patients you have a blood transfusion, a pre-op, a post-op, hypotension, so the quality of care – it is not that quality – we are trained to prioritize, we are trained to undergo very stressful care. When I came here I had how many residents – compared to back home – it was more stressful [in the Philippines]. [Maria, LPN]

Similarly, Sarah commented, "In the Philippines I've handled 20 patients at one time because we're understaffed" [Sarah, LPN]. She went on to explain that in the Philippines she was also expected to work in multiple areas within the hospital. "Every week we are rotated and we have different cases. This week we may be in the medical ward, next week in the surgical ward and then pediatrics ward" [Sarah, LPN]. Sarah preferred working in Canada, with fewer patients and assigned to just one unit. She remarked, "I think I like it better this way we will be able to know your patients more, you will be able to know their routine, you will be able to assess if there are any unusual occurrences you know" [Sarah, LPN].

Likewise Ramon told how he preferred the lower patient ratio in Canada, as it allowed more time to focus on the health needs of each client. He explained:

> [In the Philippines]there are only two nurses covering a 40 patient ward and one HCA so you will have all of your time in the paper works and doing the charting and then the other one will do the medications. So instead of being at the bedside you will be doing all those stuff and HCA will do their vital signs. Unlike here you only have 6-8 patients so you are more focused on your patient than your paper work. You would know a lot more of your patient which I think personally is a lot better because that's what nursing is. Yeah, because you could notice that some of the Filipinos do not complain if they work short, work here because they are used to working back home with 40 patients. Well, handling 40 patients, but with fewer patients you can do a lot more, we can do a lot more with the patient. [Ramon, LPN]

Finally, Nicole described how she was reluctant to take time off for illness in the Philippines, as there would be no one to replace her:

> We don't have the option of a long list of casual, like we have here. They just get the exact number of staff in the Philippines because we don't have very much of the budget and with the sick calls - literally until you have to go [be admitted] to the hospital [yourself], you should still go to work because no one is going to fill in your spot. [Nicole, LPN]

Working in a "Well-Resourced" health care system. A number of participants commented on the difference between working in Canada, in a health care system that they perceived to be well-funded, as compared to the Philippines, in a health care system that they described to be inadequately funded. Participants remarked on the resourcefulness of Filipino nurses and voiced concerns over observed wastefulness amongst Canadian nurses:

> In the Philippines you are taught to be efficient, to use the resources that you have – because sometimes we are out of supplies – understaffed but here you have all the resources right. You know what, when I first worked, morphine for example, morphine – we only give one mg, 0.1 ml, and sometimes the patient does not ask for breakthrough, so you waste that .9 in the Philippines we would not do it. I'm shocked – there's a shortage but you waste. [Sarah, LPN]

IENs discussed how, in the Philippines, the treatment provided was often governed by the patient's ability to pay. This limitation created a number of challenges and often changed the type of care they were able to provide:

> In the Philippines it is quite hard – we see a lot of patients there too. And it's, you deal not just with the clinical stuff, you deal with their personal problems too. So how can I match this. It's pretty much the same except that I find that the patients here, how can I say this, they have the means, say with their medication and everything if you need to give them this whole treatment of antibiotics for one week or two weeks they are able to take it – back in the Philippines sometimes it's hard because some people cannot afford to have a whole treatment of antibiotics so you have to work something else out. [Grace, RN]

Likewise, Michelle explained:

> In the Philippines the whole system there works differently. So where I have volunteered it is a private hospital and in that hospital there is a general ward and it depends how much a person can afford – so basically your approach to patients and families is different. We encourage them to be part of the care. If a husband is in hospital the wife is expected to help with the personal care they are not totally dependent on us we will just give them the instructions and the patients because they pay. [Michelle, RN]

The roles and responsibilities of nurses in Canada. The survey results revealed that a total of 38% of LPNs and 48% of RNs perceived the roles and responsibilities of nurses in Canada as different compared to the Philippines. A Mann-Whitney U Test was conducted to compare the responses between LPN and RN participants. The results indicated no significant difference in scores: LPNs (Md=3.00, n=80) and RNs (Md = 3.00, n= 83), U=2970.000, Z=-1.198, p=.23. r=0.09. During the telephone interviews, adjusting to the differences in nursing scope of practice between Canada and the Philippines also emerged as a key challenge amongst participants. Both RN and LPN participants described differences in collaborative and autonomous practice. As well, the LPN participants described challenges with role ambiguity, not fully understanding the differences in the scope of practice of LPNs as compared to RNs in Canada.

Autonomous and collaborative practice. Interview participants were asked to describe how their nursing practice in Canada compared to their nursing practice in the Philippines. IENs indicated that while there were many similarities in nursing practice, nurses in Canada had more autonomy in their role. Joseph, comparing nursing practice in Canada to both the Philippines and the Middle East, noted:

> It is just about the same the only difference that I noticed is that there is more independence. The nurses here, unlike the nurses [in the Philippines] or in the Middle East where they do what the doctors tell them to do… Here you are on the front line, you assess, you decide if you are going to call the doctor. You are given that independence to practice your profession to the full extent. [Joseph, RN]

Patricia commented that her nursing practice in the Philippines was limited in scope, in comparison to Canada. In the Philippines, her responsibilities primarily involved patient monitoring, whereas in Canada, her scope was expanded to include assessment and clinical decision making; areas that would have been the chief responsibility of physicians in the Philippines:

> Back home… we are limited in our nursing job. Where I worked there was intern, resident, anesthesiologist and surgeon so there are so many people along the way to do the job, so we are just limited to nursing job, and looking after the patient. Umm the scope of nursing, of practice of nurses back home are different back home. For example, I didn't listen to chest sounds and abdominal sounds back home. It's all the doctors, we are just there to check if IVs going, patient has no complaints… We cannot do everything without them telling us what to do but here you have your protocols - you can start this. [Patricia, RN]

The continuous presence of physicians on the units in the Philippines, as compared to Canada where physicians work primarily in offices and clinics, was discussed by a number of participants. IENs commented that, in the Philippines, the ready availability of physicians meant that nurses had limited responsibility for decisions, while in Canada they were expected to assume greater accountability. Patricia further remarked:

> Nurses here are more – they are entitled with their own actions – really forced to be the leader at some point – especially if you are the charge nurse – but back home you always have a backup there is always a doctor around – you could say, I'm a nurse and he is the doctor so he will solve your problem. [Patricia, RN]

Likewise, Anna explained:

> Yeah they are still the same – here it just involves more critical thinking. In the Philippines the doctor is always there. Here you have to call them, or page them, and you have to be calling for the right reasons, and sometimes they even ask you questions, and ask you what you think. In the Philippines the doctors don't really ask the nurses anything – just tell you what they want ordered. [Anna, RN]

The collaborative nature of nursing practice in Canada was also described by participants. As Angelica remarked, "in Canada it is more multidisciplinary" [Angelica, RN]. Equally, Patricia noted that in her work as a nurse in Canada, she worked with a number of different health professions: "You are dealing, not just with your fellow nurses, but with HCA, social workers, your director, your manager, everyone like down to the housekeeping you have to interact with everyone so it's different from back home" [Patricia, RN]. For Anna, collaborating with the interdisciplinary team was stressful: "I still find it stressful for me – now they have trained me for doing charge and now I have to collaborate with doctors, PTs and OTs… but I think it's getting better – but I'm not there yet" [Anna, RN]. By contrast, Angelica liked the ability to have input into decisions. Comparing her involvement in clinical decisions in the Philippines to Canada, she commented: "Mostly we can't do without a doctor's order, or without your superior's approval, while in here you make your own judgement and at the same time you talk to your superior about your judgement and they listen to you" [Angelica, RN].

Role ambiguity: LPN versus RN scope of practice. LPN participants were asked to describe their scope of practice as a LPN in Canada. While the majority of LPNs described their scope in terms of the specific nursing skills they could perform, or by the ability to assume charge responsibilities, uncertainty regarding the differences between the RN and LPN scope of practice was apparent in many of the responses provided. As Nicole noted, "there are a few things – some medications, but not too much. It is not really clear what our scope of practice of LPN is" [Nicole, LPN]. Likewise, Edward noted, "We are almost doing everything that an RN does and only we are not permitted to be in charge and there are some medications that we can't give IV push" [Edward, LPN]. Similarly, Joan observed:

> In my place of work there are some things that an LPN nurse cannot do like being in charge of the unit. I think it is also the same with some hospital based LPNS. And I think when it comes to blood transfusions…There are only a few differences in terms of the scope of practice. [Joan, LPN]

Recent changes, expanding the LPN scope of practice, further added to the confusion. Isaak explained:

> Umm back home I was an RN, and like, the roles and responsibilities are really broad – like you do everything. Here as a LPN – the RN and the LPN has a very close roles and responsibilities – it's not that far, they are almost the same it's just the RN handle more critical patients their roles and responsibilities are greater than an LPN. [Isaak, LPN]

The perceived similarity in scope of practice raised concerns about the pay differential between LPNs and RNs. As Joan commented, "LPNs are not happy with how things are because you do the same things as RNs but the fee, there is really a big difference" [Joan, LPN]. And Ramon remarked, "it would be a lot better if I worked as an RN because it is just the rate that is different. I don't see much of a difference between the LPN and the RN on the roles and responsibilities, there's not lots of difference" [Ramon, LPN].

The negative attitudes and behaviours of others. The challenges associated with adjusting to the nursing workforce in Canada were most frequently reported by participants. However, a number of participants also described the negative attitudes and behaviors of others that they encountered throughout their integration into the health workforce. Racist attitudes and discriminatory behaviours, bullying, and unsupportive behaviours were described.

Discrimination on the basis of race or ethnicity. Survey participants were asked if they felt they had received equal treatment compared to Canadian educated nurses. While the largest percentage of participants responded that they did not agree that their race, ethnicity, or colour had an impact on their work life, a concerning number reported that they agreed or strongly agreed that they had experienced discrimination within the work environment (see Table 47). Relations with both colleagues and patients were the categories most frequently identified by participants. A total of 25% of RNs and 22% of LPNs agreed or strongly agreed with the statement that their race, ethnicity, or colour had an effect on their relations with colleagues. Similarly, 23% of RNs and 27% of LPNs agreed or strongly agreed with the statement that their race, ethnicity, or colour had an effect on their relations with their patients.

Table 47. Equal Treatment to Canadians – RNs and LPNs

My Race/Ethnicity/Colour has had an effect on…..						
Frequency (%)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	md
My hiring/getting a job as a nurse	29 (17.7)	68 (41.5)	34 (20.7)	27 (16.5)	6 (3.7)	1
Where I work	25 (15.3)	67 (41.1)	34 (20.9)	32 (19.6)	5 (3.1)	2
My relations with my colleagues	21 (12.9)	57 (35)	45 (27.6)	37 (22.7)	2 (1.8)	2
My relations with my manager	25 (15.3)	68 (41.7)	35 (21.5)	26 (16.0)	9 (5.5)	2
My relations with my patients	18 (11)	59 (36.2)	45 (27.6)	38 (22.1)	3 (1.7)	2
My training opportunities	28 (17.1)	74 (45.1)	23 (14.0)	33 (20.1)	6 (3.7)	1
My performance reviews	28 (17)	71 (43.3)	29 (17.7)	30 (18.3)	6 (3.7)	1
My ability to be promoted to a higher nursing position	26 (16.3)	59 (36.9)	45 (28.1)	21 (13.1)	9 (5.6)	5

The qualitative comments provided by survey participants provided further insight into the discrimination experienced by some IENs. For example, N.R. wrote, “My race SOMETIMES affects how some of the patients perceive my competence as a nurse.” N.R. continued, “some patients surely are racists” [N.R., LPN]. U.Q. noted that although negative experiences were the minority, they still occurred:

> [The] majority of the patients I have dealt with treat us the same way as any other nurses. Most patients are thankful, saying they recognize the shortage of nursing in Canada and are happy in having Filipinos as their nurses, which is very heartwarming. However, there are those odd ones who are explicit in their 'dislike of Asian nurses,' and could be verbally abusive. [U.Q., RN]

Survey participants also described some of the responses they had encountered with other nurses. One common feeling described by a number of participants was the need to prove their knowledge and abilities to Canadian nurses before they were accepted. E.F. wrote:

> I had such a difficulty in dealing with OR NURSES SPECIFICALLY RNS to prove [my] knowledge and skills in the OR! First year at the [hospital] in the main OR there were 80% of my day that I go home crying bec of discrimination bec of my colour and they cannot accept that I can do my job even if I'm just a low paid nurse (LPN)" [E.F., LPN].

Similarly, G.Q. remarked, **"**I worked in the rural area of [Province] before.And I experienced work related bullying there maybe because of my race.Until I prove to them that I can perform as good as them even though Im not educated here" [G.Q., RN]. One participant commented on how she felt that her Canadian colleagues took advantage of her, assigning her unwanted tasks or more challenging patients. While she was working and being paid as a LPN, she felt she was unfairly assigned a heavier workload as she had been a RN in the Philippines. She wrote:

> During the first few months when I first worked in my unit I felt like they depend so much dirty work on me as I all answered call bells for most of their patient and for me they are expecting me to always do that even when you get busy with your own patient …they never appriaciate that even if they saw you tired while they are just sitting on their butt. Sometimes if you tolerate that actions they will abuse you. Filipinos are dependable but don't abuse… there's an imaginary wall that divides the Asian and the white people. If they don't like the staff they assigned heavy patient and not considering if you are LPN and RN's get lesser assignment and more stable patient. I hate when they do that because they are not worried if you are working as LPN here what they see is my skill as international RN. They will say you are working as RN back home then you can do that workload. [E.G., LPN]

These findings were further supported by the comments of the RN and LPN participants during the telephone interviews. As with the survey responses, interview participants noted that negative attitudes directed toward them were expressed by a minority of individuals; however, a number acknowledged that they had encountered racist attitudes or experienced discriminatory behaviour while working as a nurse in Canada. As Anna explained:

> For the most part people have been very supportive. But I honestly, I would say racism would always be here. Even if we don't recognize it. I would not hold it against people, it's just the way it is right now, people from a country – I'm not from here and they don't understand them and they are not comfortable with people from a different race. So for me that is fine – I just do my job and it's OK. [Anna, RN]

Likewise, Isaak commented:

> ummm I would say … some are indeed helpful, they want you to succeed and they hope you could be an asset to the unit – especially to staffing and building a sense of team on the unit – some want to help you succeed. Others, yes I do experience racism, treating you unfair. It's like the way you – like in your relationship in the workplace - there is like a gap. I don't know how to explain it but you can actually feel it. Some people don't like to help you or they don't give effort, they appear like they are busy and they don't have time to help you. [Isaak, LPN]

The issue of discrimination was further explored in the interviews conducted with URHWs. A large number of the URHWs interviewed agreed or strongly agreed with the statement that their race, ethnicity, or colour had an effect on their relations with their colleagues (50%), managers (50%), or patients (90%) (see Table 48).

Table 48. Equal Treatment to Canadians – Unregulated Health Workers

My Race/Ethnicity/Colour has had an effect on…..					
Frequency (%)	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
My hiring/getting a job as a nurse	-	8 (80)	-	2 (20)	-
Where I work	-	7 (70)	-	3 (30)	-
My relations with my colleagues	-	5 (50)	-	4 (40)	1 (10)
My relations with my manager	-	5 (50)	-	3 (30)	2 (20)
My relations with my patients	-	1 (10)	-	9 (90)	-
My training opportunities	-	8 (80)	-	2 (20)	-
My performance reviews	-	6 (60)	-	4 (40)	

Participants described derogatory remarks directed toward them by clients. A number of respondents also voiced the belief that they could not respond to the comments and simply

needed to accept the patient's remarks. As Tala explained, "Some of my patients - sometimes are uhh shouting like – 'you are a Filipino' – 'all of you are taking our money', Yeah, it's quite hard when you have a patient like that -you just can't argue with him. I just don't say anything" [Tala, URHW]. Lilibeth commented, "Umm because sometimes my experience would be treated like – you go back 'in your own home' or 'in your country'. Um I just say like I'm here to take care of you and I'm just doing my job -so please, umm accept me" [Lilibeth, URHW]. Likewise, Arvin described, "Well sometimes, umm, they prefer, there was one patient I was trying to help but she preferred my Canadian colleague. I understand, I understand, I never complained, I just respect what the patient wants" [Arvin, URHW].

The URHWs also described negative attitudes expressed by employers and managers. For example, Malaya explained how she felt her manager treated her differently than her other colleagues, paying closer attention to her work and double checking that she did things correctly:

> With my manager, because when I started working and I've been working with her for over a year, and I can feel that she doesn't trust me like my colleagues work with the same race as her, and she is more observant and more critical of my work and how I do things and she is more, always looking into my work, in my journals and everything I do – she is double checking everything compared to others. [Malaya, URHW].

Another participant described an unpleasant working environment and the employer's unfair treatment of Filipino workers. Riza, reluctant to say no to her employer as she was still a TFW in Canada, complied with the employer's demands:

> Um with the company I'm working with right now it's never been very pleasant when it comes to how they treat, not just me, but my fellow Filipinos who are coworkers as well. Like with the shifts they are giving us it is always difficult to say no as a temporary worker. They would always push us to do it**.** [Riza, URHW]

Further comments made by Riza revealed that she was being exploited by her employer. She explained how her employer scheduled her for overtime shifts but did not pay the required time and a half. She believed she was not entitled to overtime pay as her employer had wrongly informed her that, in accordance with Alberta law in a homecare setting, he was not required to pay overtime:

> Well, technically on my contract I'm supposed to work 40 hours per week, but that never happens, I am always over. They're always short…. The thing is because I work with home care we don't get any time and a half at homecare – we're just paid a flat

> rate. I think it's in Alberta labour law – we only get flat rate and never get overtime unless it's a holiday – a statutory holiday. Not so good. I'm not so sure if that's how it is – but ever since I got here [my employers] been telling me that's how it is. [Riza, URHW]

Unsupportive and bullying behaviours. A number of the RN and LPN interview participants indicated that they had felt unsupported or bullied by colleagues. Although participants remarked that the majority of staff were supportive, IENs provided examples of times when colleagues had refused to provide needed assistance or engaged in bullying behaviour toward them. As Patricia explained: "There are some people who are very helpful, accommodating, specifically I would say there are not issues and they become my friends along the way but there would be somebody who are bullying, and questioning my knowledge and my ability" [Patricia, RN]. Angelica described her experience working in a new position. From her perspective, the senior nurses were unsupportive to new graduates, whether Canadian or international, which influenced the turnover rates of new nurses on the unit:

> ummm when I started working on the surgery area as a grad nurse what I noticed at that time is there is a lot of us new grad nurses coming in – a lot of nurses resigning – or working somewhere else – so the nurses working there at that time were senior nurses - or some of them not even senior but working for at least two years. And what I experience is they are not happy getting these new grad nurses – they are not very supportive – some of them are really unapproachable – some of them do not like new grad nurses - they think we're just going to ask them all the time – they don't trust you – umm, that is the experience that I had. And I just basically umm tried to minimize the questions that I have to ask for them and for the rest I just have to think of other tools and resources that are available to you in the hospital for you to know a certain thing – like policies – or you just talk to the manager or the CRN or sometimes talk to other nurses that are more approachable. [Angelica, RN]

Another participant described how a recent Canadian graduate nurse had questioned her ability to administer a subcutaneous injection in front of a patient. While she stated it was "funny," she went on to explain how she had felt belittled:

> First I'll tell you the bullying. You know there are some nurses that are treating you like you don't know anything. I have one example that is funny. When you give a blood thinner in the tummy, you know it bleeds sometimes. [pause] And then I have this- she is a fresh grad and she said 'do you even know how to inject a subcutaneous medicine"? She did that in front of the patient – I feel so very small. [Jeffrey, LPN]

Hannah described receiving support from her nursing colleagues and the manager but received little support from the URHW on the unit:

> I'm working with an old nurse already and she is very supportive. She has taught me a lot. I really like working with her and the other one too. My Manager is very supportive too. The hardest part – because you are just starting, the HCA thinks, what do you know? – and you are still learning... you still don't know all the residents because its long term care and you have to deal with them and take care of them every day and you need to know different approaches for each resident – so you are still learning from everyone … the managers, the bosses they were OK but she [HCA] was the most - She gave me a hard time. [Hannah, RN]

The reported lack of support provided by other nursing staff also had the potential to impact patient safety. Rather than intervening to provide assistance and prevent an error from occurring, Christina described how staff members had allowed her to make mistakes: "There was like one or a couple of staff. Usually, or most of the time they watch you make mistakes before reporting to the manager" [Christina, LPN]. Another participant noted that when staff were supportive, it was possible to discuss care and correct errors before you made them. When staff were unsupportive; however, mistakes were more likely to occur: "Some people don't like to help you or they don't give effort, they appear like they are busy and they don't have time to help you. Sometimes you can talk it over first, if you [make] a mistake you can always talk it over first and correct it" [Isaak, LPN]. Isaak noted that "some people write you up right away" [Issak, LPN] and felt in these situations staff were more concerned with reporting mistakes than preventing them.

Section Nine: Integrating Into the Regulated Nursing Workforce in Canada: Supports

> **Research objective: Identify the supports that nurses from the Philippines utilized while integrating into the Western Canadian workforce.**

Participants identified a number of programs and resources that were helpful in supporting their integration into the nursing workforce. The following section will discuss, the source of information for IENs regarding their first nursing position in Canada, employment supports, bridging programs, as well as the support received from family, friends and other nurses.

Source of information regarding first nursing position in Canada. The largest percentage (33%) of survey participants identified that an internet or newspaper advertisement was the primary source of information regarding their first nursing job. An additional 25% of participants indicated that they found out about their first nursing job by working in another position as a student, URHW or volunteer within the facility. 22% of participants (15% of RNs and 29% of LPNs) responded that they had been actively recruited into their first nursing

position while working in the Philippines. Of note, 16% of participants identified that family, friends, IENs, or members of the Philippine community were either the sole source of information or one of a combination of sources of information regarding their first nursing position in Canada (see Table 49).

Table 49. Source of Information Regarding First Job as a Regulated Nurse in Canada

Frequency (%)	RN*	LPN*	Total*
Internet/newspaper	37 (45)	17 (21)	54 (33)
Family, Friends, IENs, Philippine Community	6 (7)	7 (9)	13 (8)
Recruited in the Philippines	12 (15)	23 (29)	35 (22)
Previous job in another position in the Hospital/Facility	14 (17)	27 (34)	41 (25)
Combination of Sources			
Internet/newspaper **plus** family, friends, IENs, Philippine Community	6 (7)	4 (5)	10 (6)
Previous job in another position in the Hospital/Facility **plus** family, friends, IENs, Philippine Community	3 (4)	1 (1)	4 (2)
Other (Submitted Resume, Telephoned, Applied in Person, Not Specified	5 (6)	1 (1)	6 (4)
Md	1	1	2
	84	**81**	**165**

Employment support: Orientation. Attending hospital orientation was considered very helpful by 62.8% of both RN and LPN participants. Working with a preceptor was also considered helpful with 65.9% of participants ranking it as very helpful and 26.2% indicating it was quite helpful in assisting with their adjustment to their first nursing position (see Table 50).

Table 50. Perceived Helpfulness of Orientation

	Very Helpful	Quite Helpful	Neutral	Not Very Helpful	Not At All Helpful	None Provided	Md
Hospital Orientation	62.8%	27.4%	-	1.2%	-	8.5%	1
Working with a Preceptor	65.9%	26.2%	.6%	2.4%	.6%	4.3%	1

Note. Valid % (n=164)

During the telephone interviews participants were asked to describe the orientation they had received from their employers, when they first began working as a nurse in Canada. The answers amongst participants varied considerably. While some IENs described a comprehensive orientation offered over several months, others indicated that only a few days of orientation had been provided. For example, Joseph received a comprehensive orientation that included one month of general orientation, followed by two months of shifts with a preceptor:

> When we came here it was May we spent the whole month in Brandon orienting about the regional protocols and policies all of that was done in Brandon. Then after a month we were assigned to the hospital we were going to work in and we were given one mentor …So every time they would work we would go along with them and work with them. [Joseph, RN]

Whereas, Sarah was provided with only a few days of orientation, after which she was expected to work independently. Sarah explained that she obtained her license as a LPN after being away from nursing practice for two years. When she started her first position as a LPN in Canada, she was only given 6 shifts of orientation; essentially she had to figure things out on her own:

> I haven't worked with a preceptor. Because when they granted me the permit umm, they told me that I can work directly as LPN. But when I entered hospice I was able to do 6 shift [orientation] shifts – that's all. I would love a longer period because it's really a big adjustment because for me, for two years, I haven't done nursing work – right. I haven't given medications, I haven't done nursing skills and then after 6 shifts I was able to go on and work as LPN so right now umm, it's still a learning process for me, because you don't get all you're needing to learn on six shifts orientation alone. So you just hope your colleagues are more supportive. I'm adjusting, I'm currently

> adjusting and when I encounter things I don't know I read, I watch videos umm, I review nursing skills because if no one will help me then I have to – right? [Sarah, LPN]

Likewise, Patricia described how she received just 3 days of orientation to the rural facility she worked at: "I only had orientation for 3 days so basically I'm just trying to learn things on my own" [Patricia, RN]. She continued to explain how a number of her frustrations could have been avoided if a longer orientation had been provided:

> If you are putting people in an acute care setting you have to give them a longer orientation – I would still say nursing clearly is the same, but the equipment, policies, uh, the stuff we are using here -we do not have it [in the Philippines]. I will just give you an idea. Putting in an NG we do not have any tape to put on the nose back home – those things – if I see it for the first time – I won't know it should be on the nose. Those simple things, I would say struggling, they should give us better orientation – even the pump alone we just do it manually [in the Philippines] but here there's a pump… it wasn't in the orientation, I just basically know by experience – I just go into there and someone just show me how to do it and then later on, even the pump I didn't know that it could be put on standby - I didn't know that after two years working in [hospital] – those simple things – but it would have been helpful if someone had told us right away with a good orientation. [Patricia, RN]

Understanding policies and learning the correct procedures was a concern voiced by other participants and having this information in orientation was identified as important. As Nicole expressed, "We don't know the right way, we don't know if what we're doing is right in the Canadian context or not" [Nicole, LPN]. Ramon described his first introduction to the cardiac care protocol. As he explained, he did not find it difficult to learn and found the protocol straight forward once he was familiar with it, but it took time:

> Umm I first encountered a flow sheet, if someone comes in with chest pain you have a flow sheet to follow, a care plan to follow. The triage was new to me as well but when you work night shift you have to do it because there is no one else on the floor…I didn't find it difficult it just takes time, time, time, because honestly in some ways it's a lot easier, you have a care plan already planned out for you, all you have to do is follow it. [Ramon, LPN]

He felt, with a longer orientation, he could have been introduced to the protocols and been better prepared to work in the emergency ward: "They gave me just a month of buddy shifts. That is still not enough because it is a new position for me in the ER and I am trying to learn, it is a 360 degree shift. Although it was quite helpful, but in that span of time for a month, it was helpful but not enough" [Ramon, LPN].

All participants spoke of the inclusion of "buddy shifts," where the IEN was partnered with an experienced nurse, as a helpful part of their orientation period. When Edward was asked about the most helpful component of orientation, he responded, "umm most beneficial - I think that would be the buddy shifts" [Edward, LPN]. Likewise, Pearl commented:

> I had a one month orientation – my last orientation was just last Sunday. [Researcher: Did that include buddy shifts?] Yes, umm there is a certain LPN that showed me all the time and when I do procedures – though I do myself there is someone supervising me and I ask a lot of questions if I'm not sure what I'm doing. [Researcher: Was your orientation long enough?] Umm so far for me yes, umm well maybe it would be better if it was going to be longer a few more shifts. Because sometimes you are not able to encounter procedures. [Pearl, LPN]

Finally, two participants, who had worked in other countries before moving to Canada, offered suggestions as to how orientation could be improved. Based on her experience in the Middle East, Bea recommended at least 3 months of shifts with a preceptor: "I think you should have enough buddy shifts. Like for us working in the Middle East you have at least 3 months buddy shifts. Especially if you are internationally hired nurses. I think buddying is a really good thing when you are educated internationally, when you didn't study here in Canada" [Bea, RN]. She continued to comment that preceptors should be required to hold a certificate, as there is a specific skill set needed to be an effective support:

> And another thing, like a preceptor or a person who is a buddy should have a certificate that they can buddy a person. It's not like your supervisor is just going to pick you out and tell you that you are going to be a buddy with this person, no matter how experienced you are because like with that certificate you are going to learn how are you going to approach the person in a way that is going to be constructive and not intimidating and that way it is very positive for them and encouraging for them and you know the right approach for the person you are buddying with. [Bea, RN]

Similarly, survey participant Jennifer remarked that she felt the one month orientation she had received in Canada was not adequate:

> I would say if only they would provide a longer orientation then it would have been easier. Umm, because they think once – you learn as you go along - but sometimes learning as you go along you commit more sort of mistakes and I don't want to do those sort of mistakes. So only if there's umm, there's a own sort of, only if there's like a longer orientation I would have known how Canada, how the hospital is doing things. After a 1 month orientation you cannot learn everything. [Jennifer, RN]

However, she remarked that the 6 month adaptation program she had been provided when she first migrated to the UK had prepared her well for practice in a new country:

> When I was in UK they were really good with full orientation for umm foreign nurses like us. We didn't need to take an exam so when I move in the UK it's more on the job training – adaptation nurses – so they would provide us with 6 months for this adaptation… So 6 months of orientation, quite really a big sort of help for Filipino nurses like us. [Jennifer, RN]

Bridging education. Survey participants were asked if they felt attending a bridging program had helped them adapt or adjust to their first nursing position. A total of 30 RN participants indicated that they had completed a bridging program. Of these, 90% [n=27] ranked bridging education as very helpful or quite helpful in assisting them to adapt to their first nursing job. An additional 43 LPN participants indicated that they had completed bridging education as part of the LPN licensure process. Of these, 97.7% of participants (42/43) ranked bridging education as very helpful or quite helpful in assisting them to adapt to their first nursing position (see Table 51).

Table 51. RN and LPN Bridging Education: Helpfulness Adapting to First Nursing Job

Frequency (%)	RNs	LPNs	Total
Very helpful	18 (60)	27 (62.8)	45 (61.6)
Quite helpful	9 (30)	15 (34.9)	24 (32.9)
Neutral	-	-	-
Not very helpful	-	1 (2.3)	1 (1.4)
Not at all helpful	-	-	
md	3	-	
Total	30	43	

The perceived helpfulness of bridging education was also explored during the telephone interviews, and participants' comments supported the survey findings. As Anna remarked, "Yes [bridging education] definitely helped me working because there were some things that I needed to learn" [Anna, RN]. Likewise, Patricia found bridging education helpful in assisting with her transition from LPN to RN practice: "It helped a lot, even though I worked two year [as a LPN in a Community] and close to two years [as a LPN in a second community], but when I took the [RN] bridging program there were so many things I didn't know and I learned, so this is how we do it!" [Patricia, RN]. Comparing her experiences after taking a bridging

program to other IENs on her unit who had not been required to enroll in bridging, she concluded that all IENs would benefit from bridging education:

> Initially this assessment thing and this bridging program, really, I was really disagreeing, but after going through this, I would say this is the best thing that they are doing now. Umm for example, [other IENs] when they came here they applied to other provinces, far, far away – Nova Scotia - where there is no SEC at that time and some of them got a GN license and wrote the exam and passed and some of them hired in Manitoba and they basically have no orientation and everything – we all came at the same time, and I would see the difficulty they would have, and they really didn't know what was going on, they had to learn from experience. So compared to IENs who went through the bridging program, they were just thrown into the Canadian system – I would find it – it would be easier for everyone to go for a bridging program. [Patricia, RN]

Similar comments were shared by Hannah. After taking the SEC/CCA, Hannah was told that she did not require a bridging program and was eligible to write the CRNE. Upon passing the national exam, she obtained her first position as a RN. She was provided with 3 days orientation, after which she still felt unprepared for practice. She believed taking a bridging program would have helped her transition:

> I had to buddy with umm, another nurse and I think I had five orientations – at first it was only three days and then I asked my manager – I still have to learn more – and she gave me another 2 days. [Researcher: Did you receive any other supports?] Umm, at first, maybe I needed more support because I'm still learning…that's the reason why I don't think it's a plus for me that I didn't go to a bridging program. [Hannah, RN]

Like Hannah, Sarah had not been required to attend a bridging program as part of the licensure program, so instead she planned to enrol in courses on her own. She explained: "There is a school here called Bow Valley College that will offer short courses to refresh LPNs. How to assess, medication administration, intradermal, that's my plan. So it will boost my confidence as well" [Sarah, LPN].

Some participants remarked that while bridging education was helpful, they would have liked to see more emphasis on clinical practice experience. For Grace, instead of four months of classroom instruction and two months of clinical practice, she would have preferred three months for each. She explained:

> I still find it really helpful for me because I don't have much experience back home in nursing practice. I would suggest a longer practicum because two months for me wasn't enough. When I was in the practice setting I still feel - I was still so anxious

> to do a lot of things that required me… 3 months for classroom and 3 months for the clinical. The education, like the knowledge is there but the skills are not. Especially for nurses like me. So I couldn't tell for other nurses who have been practicing for a long time. It's like for example the equipment that we're using, the tools that we're using were different so those are some of the things we need to learn too – beside the nursing knowledge. [Grace, LPN]

Equally, Christopher suggested:

> Filipino nurses as a whole learn from experience, learn more from experience,...so expose them to the field more, rather than let them sit in the class room. Because these are nurses, they've studied four years, they know the theories they know the theory behind the profession of caring. Expose them to the field because in a foreign land we have different approach to things, we have different clientele so - for you - if you want your people to be great nurses expose them to the field more, where the challenges are, where they can learn more things. Experience is a great teacher. Like give them time to learn in the field before sending them off on their own. [Christopher, RN]

Support from family and friends. Survey participants were asked to identify any other sources of support that helped them adapt to their first nursing position. A total of 13 survey participants indicated that family and friends had been a helpful source of support.

Support from other nurses. The majority of participants found the support they received from other nurses was helpful in assisting with their adaptation to nursing in Canada. A total of 94.5% of participants indicated that other nurses were quite helpful or very helpful, and other IENs were considered quite or very helpful by 91.5% of RNs and LPNs (see Table 52). Similarly, the majority of RN and LPN participants agreed or strongly agreed that their work colleagues understood (55%) or considered (56%) their cultural perspectives.

Managers were considered quite or very helpful by 86.4% of participants, and educators were considered quite or very helpful by a total of 79.8% of participants (see Table 52). The majority of RN and LPN survey participants agreed (49%) or strongly agreed (14%) with the statement that they were given adequate time to achieve competence in new skills within their current position, and only 13% of participants strongly disagreed or disagreed with the statement.

Table 52. Perceived Helpfulness of Support from Managers, Educators, and Other Nursing Staff – RNs and LPNs

Percentage %*	Very Helpful	Quite Helpful	Neutral	Not Very Helpful	Not At All Helpful	None Provided	md
Other Nurses	64%	30.5%	2.4%	1.8%	-	1.2%	1
Other IENs	56.1%	35.4%	2.4%	-	.6%	5.5%	1
Manager	60.1%	26.4%	5.5%	4.9%	1.2%	1.8%	2
Educator	52.8%	27%	4.3%	3.7%	1.8%	10.4%	2

Note. *Valid % [total n-md]

The qualitative comments provided by a number of survey participants supported these findings. H.F. wrote, "I work in an awesome place and my co-workers are very supportive when I came here 4 years ago" [H.F., LPN]. Similarly, W.D. commented, "Canadians are a very welcoming and considerate people. I am very happy with all the help and support I received from colleagues during the registration process and throughout my employment" [W.D., RN]. And S.O. described the support she had felt from managers and physicians: "I appreciate that managers and doctors in Manitoba understand our learning needs and adjustment periods and are not over-assuming that we should know many things nor underestimate our knowledge and skills" [S.O., RN].

Likewise, during the telephone interviews, participants commented on the support they received from colleagues and managers. Grace stated, "I was grateful that my colleagues were very supportive" [Grace, RN], and Ramon remarked, "the supervisor was really, really supportive of me if I asked for about another buddy shift she would give me and if I asked her if I wasn't comfortable in doing this, she was OK with it" [Ramon, LPN]. Similarly, Jennifer described the support she had received from her manager in encouraging professional development: **"**My manager has been ever so good with me in terms of my professional growth and everything. She tried to push me to do something to do something to get me better…My manager has been supportive" [Jennifer, RN]. For Jeffrey, the support he received from other IENs helped his transition to nursing in a new country.

He remarked:

> Working in a new country, working in a new hospital, with new culture, anxiety is very high. But with the help of my coworker – there are lots of Filipinos on my unit who also came from UK because in my unit there are 15 of us. 5 are from the Philippines and we work as LPN; 5 are from the UK – they work there for 10 years already and 5 are from Australia so it's kind of like [pause] Most of the Filipino nurses from the Philippines are in their 20's and the others are in their 30's 40's so they are like our mentor - kind of like asking what are some of the ways they can help. So I would say we have good support on our unit – from Filipino nurses. [Jeffrey, RN]

Summary

The findings of the mixed analysis revealed that participants identified four main reasons for migrating to Canada and the Prairie Provinces. These included the presence of family in Canada, the demand for nurses in the Prairie Provinces, ease of migration, and the opportunity for a better life. Upon entry into Canada, IENs encountered challenges in both the pre-licensure and post-employment phases. Financial constraints, obtaining the necessary English language proficiency levels, and meeting the RN licensure requirements were the key pre-licensure challenges identified. Post-employment, IENs reported challenges with language and sociocultural communication, obtaining the required knowledge and skills, adjusting to different resources, conflicting values, and professional and collaborative practice. IENs identified a number of supports and programs utilized to facilitate nursing workforce integration.

IENs from the Philippines were employed in the Prairie nursing workforce as RNs, Licensed Practical Nurses (LPNs), and unregulated health workers (URHW). IENs pursued LPN practice as a *Stepping Stone, Parallel Process, or Alternate Career Path,* to RN practice. The main reason cited for working as a URHW was the need to find a *survival job* while working through the nursing licensure process.

Chapter Five: Discussion

The discussion chapter has been divided into six sections:

- Migration to Canada
- Entry into Canada and Workforce Integration
- Becoming a Regulated Nurse in the Prairie Provinces: Challenges and Resources
- The Decision to Work as a LPN or URHW
- Workforce Profile
- Working as a Nurse: Challenges and Resources

Section One: Migration to Canada

The reasons IENs chose to migrate to Canada varied, with some describing the 'push' away from the Philippines and the 'pull' toward Canada, while others spoke of the importance of established networks of family and friends in Canada. The ease of entry into Canada was also a key consideration for a number of participants and for some the primary reason for choosing to migrate to Canada rather than other countries.

The push and pull of migration. Almost one half (48.4%) of online survey participants identified that financial factors were the primary reason for migration. For many participants the 'pull' of better job opportunities, higher wages, and professional growth were instrumental in their decision to move to Canada and the Prairie Provinces. Conversly, other participants described the 'push' of poor working conditions and low pay for nurses working in the Philippines as the primary reasons for migrating. In essence, these push and pull factors were a mirror image (Buchan et al., 2003) reflecting the perceived disparity in working conditions between the Philippines and Canada. Amongst participants, the gap between the two countries was considered significant and allowed the 'pull' of the destination country to be felt (Buchan et al., 2003). Neoclassical push-pull theory emphasizes the individual decision to migrate based on a comparison of the relative costs and benefits of remaining home or moving. One of its central tenets is the value of human capital. Individuals invest in migration, choosing the country that can provide the best opportunities (Chiswick, 2008).

The push-pull factors identified in this study were similar to those described in previous research. Prior studies have found that amongst Philippine IENs, low salaries, high unemployment rates, high patient to nurse ratios, poorly equipped facilities, and a bleak future

for nursing in the Philippines pushed nurses to migrate; while, higher salaries, employment opportunities, professional development opportunities, and a practice environment with higher standards of care pulled nurses towards a new destination (Alonso-Garbayo & Maben, 2009; Choy, 2003; Lin, 2009; Pablico, 1972; Yumol, 2009). As Connell (2010) contends, the rationales IENs have provided for moving have shown remarkable consistency over the past 30 years of research, with unequal economic and social development underlying most migration decisions.

While economic factors were the predominant reason cited for migration, a total of 21.9% of survey participants identified social factors as the primary reason for migration. Participants described the 'pull' of Canada, which they perceived as a progressive, safe country, free of corruption, and a good place to raise a family. The opportunity Canada could provide for a better life for themselves and their families was a recuring topic amongst survey respondents and emerged as a key theme during the qualitative interviews. By illustration, Maria, a single mother of three, chose to move to Canada to raise her children where she believed there would be more opportunites for her children to obtain a better education. Similarly, a number of participants moved to Canada from another country for family reasons. Michelle, who had lived in London since the late 1990s, chose to move to Canada as she believed it was a better place to raise a family. And Joseph moved from the Middle East to Canada once he learned of the potential to become a Canadian citizen and the ability to bring his family to Canada.

These findings were consistent with those reported by Dywili et al. (2013). These authors conducted a review of the literature on 'why nurses migrate' and social factors emerged as a major theme. The ability to improve the lives of family members and the benefits for children were amongst the reasons cited. Similarly Connell (2010) noted, "in Pacific island states, migrants constantly emphasise that migration is not for their own ends but to improve the long-term family prospects, especially their children's education" (p. 113).

Migration systems theory: Networks. The role of networks (micro-structures), formed through close ties between migrants and their relatives living abroad, was evident in the findings of this study. The presence of family and friends living in the Prairie Provinces was an important social factor impacting the decision to migrate to Canada. In some cases, networks were well established, sustaining and perpetuating the flow of migrants (Massey, 1998). For example, Grace spoke of her husband's uncle, who arrived in the 1970s and had sponsored a number of siblings, cousins, nieces, and nephews over the years. In other cases, the establishment of new networks was evident. The recruitment campaign in 2008 and 2009 brought a number of new immigrants to Canada. As Ramon noted he migrated to Canada to

join his wife who had been initially recruited through this campaign, and Isaak discussed his decision to move to Saskatchewan upon encouragement from a friend who had previously been recruited by the Saskatchwan Government. Finally, for some participants the desire to be close to family networks was the impetus for moving to Canada from another country. Jennifer and her husband, for example, chose to move to Manitoba, after living and working as RNs in the United Kingdom for 12 years, to reunite with family members from the Philippines who were now permanent residents of Canada.

The ability to send remittances to family members residing in the Philippines was also cited as a key financial reason for migration. For many participants, the desire for higher wages and economic stability was important in order to provide financial support to family members back home. As U.V. remarked, [I want to] " be financially stable. So I will be able to support my family in the Philippines," while C.D. noted that he migrated in search of "Greener Pasture[s] and to be able to send [his] siblings to college." The comittment many Filipino migrants have to sending remittances to family members in the Philippines has been well documented in the literature (Kelly et al., 2009). Through remittances, migrants can contribute to the economic well-being of family members who remain in their home country, and in countries where families have invested in an education with a view toward migration, remittances are often expected (Connell, 2010). The Philippines is one such country where a 'culture of migration' exists, and families view a nursing education as a 'passport' for employment overseas (Choy, 2003). Thus, for many participants, the primary reason for migration was economic. However, as Connell (2010) notes, this economic migration is situated in a social context that stresses a sense of duty and reciprocity, which is fulfilled through the transfer of remittances to family at home.

Ease of entry: Macro and meso structures. The ease of entry into Canada was described as an important reason for choosing to migrate to Canada. At the time this study was conducted, a number of policies and agreements (macro structures) were in place that facilitated the entry of IENs into Canada. First, recent reforms to the federal government immigration policies placed a growing emphasis on economic migration as a means to meet short-term labour market needs (Alboim & Cohl, 2012). As a result, the proportion of economic immigrants in Canada had steadily increased, and by 2010 skilled workers represented 66.6% of all permanent residents entering Canada (Alboim & Cohl, 2012). The changes to the Federal Skilled Worker Program restricted new applicants to those with experience in an occupation that was listed as 'in demand' (Alboim & Cohl, 2012). As Registered Nurses were included on the occupation list, applications for permanent residency

by qualified IENs were often approved. The ease of the immigration process was identified by a number of participants as the main reason for choosing Canada over another country. As Isaak explained, his main goal was migration to a Western country. He first considered the U.S. but reported that he did not apply as the economic recession in 2009 had created long delays in processing the entry visas for a number of his friends. Next, he considered Australia or New Zealand but finally chose to move to Canada as he was able to have his application "*fast tracked"* and gain entry as a Federal Skilled Worker in 8-12 months.

Second, the existence of the immigration category, Family Class, which had been established to promote family reunification, emerged as a reason several IENs chose Canada over other Western nations. For example, Angelica and her family entered Canada through the family category. Family sponorship allowed Angelica and all members of her immediate family to migrate together, a benefit she believed was only provided by Canada. Similarly, Joseph noted that the ability to sponsor his family members after he had become established in Canada factored strongly into his decision to migrate to Canada.

Finally, Government of Canada policy changes made it easier to enter Canada as a Temporary Foreign Worker (TFW) (Alboim & Cohl, 2012). While caps were placed on the number of immigrants admitted annually, TFWs were demand driven and there were no annual quotas set. As a result, in 2010 and 2011 there were more TFWs admitted to Canada than immigrants (Alboim & Cohl, 2012). Study participants recruited in the 2008 and 2009 recruitment campaigns entered as TFWs. The federal government TFW policies, along with the bilateral trade agreements in place between the Philippines and each of the three prairie provincial governments, made the active recruitment of IENs feasible.

The role of meso-structures in mediating the migration of Philippine IENs to the Prairie Provinces was also evident in this research. The active recruitment of IENs in the Philippines, along with the promise of employment as a nurse in Canada, was cited as a key reason for choosing to migrate to Canada. In some cases, this was the primary reason identified for choosing to migrate to Canada over other, previouly preferred, countries such as the U.S. Jeffrey, for example, had formerly applied to work in Vermont, but while waiting for his entry visa to the U.S. to be processed, he was recruited by the Alberta government. As the recruitment campaign facilitated his migration and entry into the country, he chose to move to Canada instead.

The IENs who participated in this study were part of larger overseas recruitment campaigns. In 2007 and 2008, all three Prairie Provinces were experiencing a nursing shortage and each province responded by conducting active recruitment campaigns to fill vacant nursing positions. In Saskatchewan, the government led campaign resulted in the recruitment

of nearly 300 nurses from the Philippines (Government of Saskatchewan, nd). In Manitoba, job offers were extended to 123 IENs after a recruitment mission to the Philippines (Government of Manitoba, 2009), and in Alberta, two health regions contracted a third party agency to recruit IENs from a number of countries around the world (Armitage & Suter, 2010). The result of the Alberta campaign was 800 contingent offers of employment (Higginbottom, 2011). Of these 800, approximately 330 were tendered to IENs from the Philippines (Taylor et al., 2011).

Section Two: Entry into Canada and Workforce integration

Participants reported that they entered Canada through two main categories: as permanent residents or as TFWs. The majority (52.2%) of IENs entered Canada as permanent residents. A total of 41.1% entered through the Economic Class as Federal Skilled Workers, 8.9% entered through the Family Class, and 2.2% identified that they entered as permanent residents but did not specify the Class (Table 15); while almost one half (47.2%) of participants entered Canada as TFWs.

Entry as a permanent resident. Traditionally, Canada's immigration policies have been associated with nation-building, focused on population growth and the creation of a stronger economy (Biles et al., 2008). Immigrants are seen as future citizens, and as a result numerous government policies and programs have been formulated and implemented to support their integration into Canadian society (Biles et al., 2008). Immigrants who enter Canada as permanent residents are able to access English and French language instruction, settlement and adaptation programs, and newcomer information centres, to name just a few (Biles et al., 2008).

Those participants who entered Canada as permanent residents had access to a number of government programs and supports (Alboim & Cohl, 2012). Almost one third (30.4%) of survey participants indicated that government services had been very helpful or quite helpful in providing information or support during the pre-licensure period. During the qualitative interviews, participants reported accessing general immigrant support programs such as language assessment services (eg. Winnipeg English Language Assessment and Referral Centre), language training programs (eg. Red River College Language Training Centre), and settlement services (eg. Manitoba Start).

In addition, government programs specifically designed to support the integration of internationally educated health professionals (IEHP) were identified. For example, Nicole

spoke of the value of the information and resources provided by the IEHP initiative in Saskatchewan, and Grace was able to enroll in the bridging program in Manitoba at no financial cost, as the tuition fees, along with an additional $500.00 for books and supplies, were covered by the Manitoba Government Nursing Recruitment and Retention Fund. Thus, amongst the IENs who entered Canada as permanent residents, a number of different government funded programs and supports were accessed throughout the course of their integration into the nursing workforce.

Entry as a Temporary Foreign Worker. While IENs who entered Canada as permanent residents had access to a number of different government funded programs and supports, IENs who entered Canada as TFWs were ineligible for federally-funded settlement programs and services (Alboim & Cohl, 2012). For a number of participants, this lack of support acted as a barrier to integration. For example, several IENs, who were admitted as TFWs, reported additional financial burden associated with higher international student tuition fees for bridging education. Together with the need to work, both to fulfill employment contracts and to financially support themselves, this cost made it difficult for these IENs to attend the required upgrading programs.

As TFWs, participants were also vulnerable to exploitation by employers. Riza, for example, described how she was subjected to unfair treatment by her employer and was required to work overtime hours without adequate compensation. Riza felt as a TFW she could not refuse work or advocate for her rights with her employer. Similary, Maria told how she had encountered bullying from her colleagues. As a TFW, she felt at risk and concerned about possible deportation back to the Philippines; she chose to remain silent. In Maria's words, "I had encountered some kind of bullying but I could not speak up because I was a contract worker. I was afraid I would be sent home. I renew my contract every year so instead of speaking up, I just remained silent and just prayed." Similar experiences of exploitation of IENs admitted to Canada as TFWs have been documented by other researchers. Eric (2012) described how one IEN working as a domestic worker reported a work schedule that did not include any days off, as well as her employer's refusal to provide overtime pay. Likewise, Davidson (2012) reported exploitive working conditions for migrants working as live-in caregivers in Canada. Participants working as live-in caregivers reported long hours, limited leisure, and low pay.

Although not revealed in the findings of this study, the vulnerability of TFWs to fluctuations in the job market have also been described in the literature (Taylor et al., 2011). The global economic downturn in 2008 negatively impacted the Alberta economy; therefore,

Alberta Health Services (AHS) was required to undertake a number of strategies to address the nearly $343 million dollar deficit. One of these strategies included the introduction of a vacancy management policy with vacancies filled by internal candidates only. This policy impacted IENs still in the process of migrating to Alberta as TFWs, who were not yet AHS employees, as fewer positions for RNs were available (Armitage & Suter, 2010). Additionally, for those IENs already working as TFWs in Alberta, the AHS vacancy management policy created increased competition for permanent positions. When coupled with the time restrictions on work permits, IENs felt added pressure and job uncertainty (Taylor et al., 2011).

Entering through active recruitment campaigns. The integration experiences described by IENs recruited to Manitoba and Saskatchewan differed considerably from those reported by participants from Alberta. The dichotomy in responses clearly portrayed both the advantages and the vulnerabilities for IENs entering Canada through these recruitment campaigns. Participants who had been recruited through the Manitoba and Saskatchewan Governments' recruitment campaigns described a positive experience with integration. Joseph, for example, described how a representative from the nursing regulator in Manitoba had traveled to the Philippines with the health region recruitment officers, which ensured he had accurate information regarding the RN licensure process before he entered Canada. He also explained that upon arrival to Canada he was offered a permanent position, first as a graduate nurse then, after gaining licensure, as a RN.

By contrast, many of the participants who had been actively recruited to Alberta expressed concerns. For example, M.N. described how she had not been provided with adequate information regarding her employment status prior to arrival in Canada. It was only after she arrived that she received a letter indicating that she had been hired as a LPN. Other IENs thought they had been misled by the recruiters in the Philippines. Joan felt the recruiters made her believe that she would enter Canada as a LPN and once she arrived it would be easy to upgrade to RN status. She was not aware of the requirement to take the SEC/CCA or liklihood of having to take bridging courses in order to fulfill the requirements of registration. Jeffrey also felt he had been misled. Even though his contract indicated that he would be working as a nurse auxillary, he had been told by the recruiters that he would be working as a nurse. As he was unfamiliar with this category of health worker, he erroneously concluded that he had been hired as a RN. Upon arrival his status was changed from 'auxilliary' to a LPN, but he was not eligible to work as a RN. Finally, Michelle felt the recruiters had placed her in an impossible situation, promising one position and delivering another. In her words, "I said you

have put me in a catch 22 you know I wouldn't say no, I have already resigned my job what choice do I have."

These finding were consistent with those reported in an earlier study by Taylor et al. (2011). The researchers explored the experiences of IENs who were recruited during the 2007-2008 campaign. The researchers concluded there was a disconnect between the IENs pre-arrival expectations regarding employment status and the realities they experienced upon arrival. A lack of collaboration between the employer and the RN nursing regulator in Alberta meant employers were not always clear on the exact requirements for licensure as a RN. This inconguence was especially problematic for IENs from the Philippines as the majority were required by the RN regulator in Alberta to undergo a SEC/CCA and complete all the required bridging education before being eligible for a graduate nurse license (Taylor et al., 2011).

Section Three: Becoming a Regulated Nurse in the Prairie Provinces - Challenges and Resources

According to Bourdieu (1986), institutionalized cultural capital is obtained through the acquisition of academic qualifications and once obtained it can be converted into economic capital through participation in the labour force. The IENs who participated in this study possessed significant amounts of institutionalized cultural capital. All of the participants had completed their entry level education in the Philippines and held a minimum of a Bachelor's degree in nursing. In addition, 17 participants held a second Bachelor's degree in another discipline, 13 participants held a Master's degree, and six participants held a Doctorate degree in Medicine or Dentistry. Consistent with the findings of other studies (Choo, 2003; Connell, 2010; Overland, 2005), one participant noted during the qualitative interview that she had obtained her nursing qualification primarily to facilitate migration. Christina was a pediatrician in the Philippines but was advised by her sister in law to study nursing to make it easier to migrate to Canada and find work upon arrival. Thus, Christina returned to University and enrolled in an accelerated nursing program that had been designed specifically for medical doctors.

Participants also possessed capital in the form of work experience. The majority (89.5%) of IENs had paid nursing experience prior to migration to Canada. Of those with pre-migration work experience, 69% had experience in the Philippines only, 5% had experience in another country only, and 15.5% had experience in both the Philippines and another country prior to moving to Canada. A total of 81.3% of participants identified an acute care facility as the

primary practice setting pre-migration, with three quarters (75.8%) reporting that they had worked in staff nurse positions.

Meeting the regulatory requirements. It has been proposed that the value of institutionalized cultural capital varies in relation to particular social contexts (Moskal, 2013), and in the case of foreign credentials, it is the role of Canadian professional associations to determine the worth of a particular credential through licensing and qualifications recognition processes (Girard & Bauder, 2007). Participants identified a number of challenges encountered while undergoing the licensure process.

English language requirements. Although both RN (29.8%) and LPN (45.9%) participants identified that meeting the required English language levels was difficult or very difficult, LPNs perceived a greater level of difficulty than RNs (p=.000). During the qualitative interviews, participants described challenges attaining the required English language scores and having to repeat the English exam several times before meeting the necessary levels. Participants also spoke of logistical challenges, such as long wait lists for English language classes, too few testing centres, and delays in scheduling examination dates. While the challenges associated with English language proficiency amongst IENs have been well documented in the literature (Cummins, 2009; Primeau, Champagne, & Lavoie-Tremblay, 2014) the logistical challenges described by these study participants have received limited attention in previous research. Only one study was found, and consistent with the findings of this study, Borgeault et al. (2010) identified the limited availability of profession-specific language programs as an issue for IEHPs integrating into the health workforce.

Not all participants reported that meeting the English language requirements was difficult. A total of 39.3% of RNs and 15.3% of LPNs indicated that they perceived it was easy or very easy to attain the required language levels. Some IENs (Angelica, for example) reported that they were able to pass the English exam shortly after arrival to Canada, and others (Grace, for example) noted that they had researched the English language requirements prior to migration, taken the accepted English language exam, and obtained the necessary score all before leaving the Philippines.

The number of IENs who described meeting the language levels as easy or very easy is of note. The majority of research to date has focused on the barriers IENs encounter with English language skills. These findings, although limited in scope, provide a valuable perspective and suggest that integration experiences vary considerably between IENs. Those participants who possessed the necessary linguistic capital upon arrival to Canada were able to proceed directly

to the next step in the registration process, whereas those IENs who did not have the necessary linguistic competence were required to enroll in language training programs prior to beginning the licensure process. Logistical issues associated with the availability and accessibility of English language supports added further to the pre-licensure challenges experienced by these IENs.

Documents and delays. To apply for licensure participants were required to submit a number of documents to the RN nursing regulators. For some IENs, the submission of documents presented two key challenges. First, the requirement that documents had to be sent directly to the regulators from institutions within the Philippines was difficult and expensive for a number of participants to meet. Second, the expiration of documents presented both a financial and logistical challenge for a number of participants. The need to resubmit English language scores after two years was identified as particularly problematic as IENs were confronted with a lack of available test dates, as well as the added expense of repeated testing. While participants recognized the need for English Language proficiency, many questioned the need for repeated testing. For a small number of participants, repeated delays and the subsequent expiration of documents created an endless loop. They would finish one requirement, only to discover a previously met requirement had expired.

Arguably, the determination of eligibility for licensure can be a lengthy process for regulators (Benton & Morrison, 2009). Even so, the majority (73.8%) of participants in this study were able to complete the RN licensure process in under two years. However, for just over one quarter (26.2%) of RN participants, the licensure process extended beyond a two year time frame. For these IENs, the lengthy licensure process created added financial challenges and prevented them from contributing to the RN nursing workforce in Canada. Delays have also been documented in previous studies, where inefficient and time consuming licensure processes for health professionals were reported (Covell et al., 2016; Sochan & Singh, 2007).

Substantially Equivalent Competency Assessment/ Clinical Competence Assessment (SEC/CCA). Completing the SEC/CCA was identified as the most difficult stage in the RN registration process by both RN and LPN participants. Of those who had completed a SEC/CCA, 69% of RNs and 91% of LPNs ranked the assessment as difficult or very difficult to complete. LPNs were more likely ($p=.000$) than RNs to perceive the SEC/CCA as difficult. Participants found the assessment both stressful and challenging and often noted that the practical component of the exam was the most difficult. Delays in scheduling examination dates were also an identified challenge, resulting in some participants waiting in excess of six

months for an appointment. The canceling of the testing site in Alberta resulted in a number of IENs having to travel to another province to obtain an assessment.

A number of participants also commented on the perceived unfairness of the exam. The differing results between IENs with similar backgrounds led some participants to conclude that the assessment was subjective and the outcome dependent on the individual assessor. The need to undergo the SEC/CCA was also questioned. A number of participants, originally hoping to migrate to the U.S., had written and passed the U.S. national nursing exam the NCLEX-RN®. As well, several participants held a nursing license and had secured a job offer as a RN in the U.S. but could not obtain an entry visa to the country. These IENs felt trapped in a somewhat paradoxical situation, where on the one hand, they were able to practice as RNs in the U.S. but could not gain entry to the country and on the other hand, were able to gain entry to Canada but could not practice as a RN. Participants saw nursing practice between the two countries as similar and questioned why Canada could not recognize their U.S. nursing license.

Finally, a number of participants believed that their prior work experience in the Philippines was not given adequate recognition in the assessment process; despite practicing as a RN for a number of years, they were still required to undergo a SEC/CCA upon arrival. By contrast, two IENs, who had worked in another country prior to migrating to Canada, noted that their work experience in a country other than the Philippines had been considered in the assessment process. Michelle, who had prior experience in the U.K., and Bea, who had seven and a half years of critical care experience in the Middle East, were both granted graduate nurse licences upon arrivial in Canada and were not required to undergo a SEC assessment in Alberta. This finding was consistent with those reported by Taylor et al. (2011). The authors noted that in Alberta work experience outside the Philippines was taken into consideration in the RN licensing process, and IENs recruited to the province that had been educated in the Philippines but with work experience in another country (the U.K., for example) were eligible to apply for a graduate nurse license upon arrival to the province (Taylor et al., 2011).

There has been limited discussion in the research literature on the SEC/CCA process. One mixed methods study by Besner, Jackson, McGuire, and Surgeoner (2010) compared the outcomes on the SEC assessment of IENs to those of Canadian educated nurses. In the authors' words, the study "was conducted to determine if the SEC assessment process constitutes a just and equitable test of IENs' readiness to practice in Canada" (p. 4) and to determine "whether the SEC assessment process subjects IENs to the same standard of competence as expected of new Canadian graduates, or to experienced RNs" (p. 5). A convenience sample of ten IENs, five Canadian educated practicing RNs (PRNs), and four senior students (SNs) in a Canadian

bachelor of nursing program participated in the study. Participants were assessed on 193 competencies and could achieve a maximum score of 386.

The findings revealed that the mean scores on the assessment varied considerably between Canadian educated and internationally educated nurses: Canadian educated practicing nurses (Mean = 356.2), Canadian nursing students (Mean = 353.5), and IENs (Mean = 181.9). While Canadian educated nurses and nursing students could meet or partially meet all competencies, IENs were unable to meet, on average, 45 competencies. IENs did not demonstrate the same depth and range of knowledge in general health and specialty (pediatrics, mental health, maternal/newborn) areas, had greater difficulty performing safe psychomotor skills, and had less understanding of the different roles and scopes of practice of other health professionals. In addition, IENs had greater difficulty performing health assessments and safe medication administration. They also demonstrated considerable variability in clinical decision making skills.

Besner et al. (2010) noted that "without exception, PRNs and SNs performed at a significantly higher level than did the IENs" (p. 4). The authors also remarked that the assessment process included a number of different procedures, for example, standardized answer keys, peer reviews, and professional development activities that ensured the assessment findings were not "unduly influenced by personal biases (p.20)". They concluded that the SEC assessment was "a fair and equitable way to identify candidates who are inadequately prepared to meet expected standards of practice in Canada" (p. 21).

The authors also examined the participants' perspectives on the assessment process. All three groups of participants described the week-long assessment as lengthy and exhausting. None of the assessment strategies were perceived as 'easy,' but the written exams were identified as easier than the practical components of the assessment. A number of IENs remarked that they felt undervalued by the assessment process and thought the quality of their education in their home country was being questioned. IENs also noted that the expectation to know about Canadian specific resources and practices was difficult, and they would prefer being provided an opportunity to learn, work, and demonstrate what they know in a real-life setting (Besner et al., 2010).

A second study, by Stanhope-Goodman et al. (2014), explored the barriers and facilitators IENs encountered when preparing for, scheduling, and undergoing the SEC assessment in Alberta. Barriers to completing the assessment included difficulty obtaining travel documents and visas, the need to have the time to study and prepare, long wait times to book an assessment, cost of travel to the assessment centre, and expiration of English language scores. The IENs who had completed the assessment reported that the process was too long, which

caused undue stress and fatigue that they felt impacted their performance. Consistent with the previous study, participants reported that the practical components of the exam were the most challenging.

In summary, while the SEC/CCA may be an effective mechanism to assess the knowledge and skills of IENs, the results of the current study, as well as those reported by both Besner et al. (2010) and Stanhope-Goodman et al. (2014) identify a number of barriers and stressors that IENs encounter throughout the assessment process. Further research is needed to explore these challenges and to identify ways to better support IENs as they undergo this stage in the RN licensure process.

Bridging programs. Currently in Canada, bridging programs are designed to bridge gaps between the knowledge and skills the IEN has developed through pre-migration education and work experience and the entry level competencies required to practice nursing in Canada (Xu & He, 2012). Upon completion of a SEC/CCA, IENs with identified gaps receive a letter of direction from the nursing regulatory body and successful completion of the bridging program is required to be eligible for licensure (CASN, 2012; Xu & He, 2012).

Enrolment in a bridging program was a registration requirement for a number of participants in this study. For IENs the requirement to complete a bridging program was double edged. On the one hand, 94.5% of participants who attended a bridging program ranked it as very helpful (61.6%) or quite helpful (32.9%) in assisting them to adapt to nursing practice in Canada. On the other hand, participants noted that the length and cost of programs, long wait lists for enrolment, and a lack of available programs in their geographic locations were substantial challenges.

Participants emphasized that attending a bridging program had provided an opportunity to gain clinical practice experience in a Canadian health care setting and had addressed specific gaps in knowledge and skill. As Patricia noted, she felt better prepared for practice as compared to her IEN colleagues who had not been required to attend a bridging program. In her words, "they really didn't know what was going on" and she felt "they were just thrown into the Canadian system" following a brief and inadequate orientation by their employer upon hiring. Witnessing the difficulty her fellow IENs had adjusting to practice in Canada, she concluded that "it would be easier for everyone to go for a bridging program."

For some participants, the requirement to complete bridging courses was considered the deciding factor in choosing LPN over RN practice. As Christina explained, she would undergo a SEC/CCA but if the results, "require me to take 10, 13, 15 subjects just like my other friends…I would not do that." For most participants the key reasons cited for choosing not to

complete bridging education centered on the lack of feasibility (cost, length, and location) of programs rather than concerns over their ability to complete the academic requirements. Once enrolled, only 36% of bridging program attendees ranked completing the academic requirements as difficult or very difficult.

Covell et al. (2016) conducted a scoping review of the literature about the integration of internationally educated health professionals into the health workforce in Canada A total of 407 articles were included from ten different health professions. The bridging program literature represented 4% (21 articles) of the literature reviewed. The findings cited by the authors were consistent with the findings of the current study. While studies pointed to the value of bridging education, the limited access to programs as a result of limited enrolment capacity and limited delivery outside major urban centres, as well as the financial constraints stemming from the lack of affordability of both tuition and daily living expenses while attending bridging programs were amongst the themes identified (Covell et al., 2016).

From the IENs' perspective, the value of bridging education was seen in the ability of the program to address the 'need to know'. An emphasis on clinical practice experience and a specific focus on gaps in knowledge such as health assessment, gerontology and pharmacology were identified as important. Bridging programs also provided an opportunity for a number of participants to build social capital. Grace, for example, made an important connection to a Canadian employer while enrolled in a bridging program, which led to a nursing position as a RN on the unit where she had completed her clinical practicum.

These findings were consistent with those reported in two earlier studies. Neiterman and Bourgeault (2015) conducted semi-structured qualitative interviews with 71 IENs residing in British Columbia, Manitoba, Ontario, and Quebec. Participants reported that enrolment in bridging programs was the most beneficial means to learn about Canadian nursing practice. Bridging programs addressed knowledge and skill gaps and included language and cultural training as well as preparation courses for the national licensure exam. (Neiterman & Bougeault, 2015.

Similarly, Atack et al. (2012) explored IENs' experiences attending a bridging program for LPNs in Ontario. Participants identified course work that focused on health assessment skills, scope of nursing practice in Ontario, patient safety, ethical standards, and interdisciplinary practice, as well as the preceptorship experience, as particularly helpful. IENs recommended a greater emphasis on professional communication, gerontology, dementia, and clinical practice experiences in both acute and long term care settings. The authors concluded that "Bridge programs are essential to ensure that internationally educated nurses are prepared for practice in their adopted country" (p. 378).

National RN licensure exam. Amongst participants in this study, passing the national licensure exam, the Canadian Registered Nurse Exam (CRNE), was identified as a challenge for a minority of IENs. Approximately one third (36.9%) of RN participants indicated that passing the CRNE was very difficult or difficult. Similar difficulty passing the CRNE has been reported in a number of earlier studies (Blythe et al., 2009; Higginbottom, 2011; McGuire & Murphy, 2005; Taylor et al., 2011), and a 2012 report published by the Canadian Association of Schools of Nursing (CASN) confirmed that the pass rate for IENs on the CRNE between the years 2009 and 2011 was 65.3% as compared to 78.2% for Canadian educated nurses (CASN, 2012).

Recent changes to the national nursing exam in Canada may present further challenges for IENs. The CRNE was the licensure exam in place in Canada between the years 1970 to 2015. In December 2011, the RN regulatory bodies across Canada (with the exception of Quebec) announced a new partnership with the U.S. licensing body, the National Council of State Boards of Nursing. Beginning January 2015 the CRNE was replaced by the National Council Licensure Exam for Registered Nurses (NCLEX-RN) (McGillis Hall, Lalonde, & Kashin, 2016).

The impact of this change on the integration of IENs in Canada has yet to be determined. Peisachovich and Bradley (2016) compared the pass rates for IENs to the pass rates for U.S. educated nurses on the NCLEX-RN. According to their analysis, first time pass rates amongst IENs were much lower than their U.S. educated counterparts. In 2015, the first time pass rates for IENs were 30.91% as compared to 89.79% for U.S. educated nurses (Peisachovich & Bradley, 2016). If Canadian data follows a similar pattern to the U. S. data, the pass rate on the NCLEX-RN for IENs may be lower than the previous pass rate for IENs writing the CRNE. On the other hand, as a number of participants in this study had already written and passed the NCLEX-RN, the introduction of the NCLEX-RN may actually be a benefit for some IENs as the exam can be written offshore, and therefore, can be completed pre-migration, fulfilling one step in the licensure process prior to arrival to Canada.

Financial challenges and economic capital. Economic capital has been found to be a necessary asset while working through the credential recognition and registration processes for IENs upon arrival to Canada. Consistent with the findings of previous studies (Blythe et al., 2009; Kelly et al., 2009), IEN participants required significant financial capital in order to enter a regulated nursing profession in Canada. Almost one half (49.4%) of RN and LPN participants found meeting the costs associated with registration difficult or very difficult. The

length of time required to complete the RN licensure process as well as the costs associated with registration were frequently cited as factors that contributed to the financial burden.

Amongst RN participants, the majority (73.8%) were able to complete the RN licensure process in under two years. However, the remaining one quarter (26.2%) required over two years to complete the registration process (Table 27). Amongst the LPN and URHW participants who were seeking RN licensure, the length of the registration process was cited as one of the main challenges encountered. Participants described delays in accessing English language programs and testing, delays in scheduling the SEC/CCA, and long wait lists for entry into bridging programs. They anticipated a timeframe of two or three years to complete the process and consequently required a 'survival job' to meet their financial needs while working through the registration process.

The costs associated with licensure were also cited as a considerable challenge. The application fee to open a file with the regulator as well as expenses associated with obtaining original documents from the Philippines were two of the costs identified. For those participants who were currently seeking RN registration, the cost of English language testing was of particular concern. As previously noted, the high level of English language skill required as well as the expiration of test scores after two years resulted in many participants having to undertake repeated exams. In addition, the limited number of examination appointments and the lack of availability of testing centres in certain locations required some IENs to travel to other cities, adding further expense.

The costs associated with RN bridging education were also identified as a significant financial challenge for a number of IENs. As highlighted formerly, the number of required courses and the associated cost of tuition was one source of financial burden. The need to reduce the number of hours of paid employment while enrolled in bridging programs was another. For a small number of IENs who entered Canada as TFWs, the financial challenges were further increased as a result of the high costs associated with international student tuition fees.

The high cost of living in Canada further contributed to the need for economic capital. A total of 60% of RN and LPN participants reported that it was difficult or very difficult to meet basic living expenses while moving through the Registration process. During the qualitative interviews, a number of participants noted that the high cost of living in Canada as well as the low value of the Philippine peso in relation to the Canadian dollar quickly drained their personal savings. Only 14% of RN and LPN participants identified that their personal savings provided the primary source of financial support throughout the pre-licensure period.

The majority (57.6%) of RN and LPN participants met their financial obligations through full-time and part-time work. Many participants found employment within the unregulated health workforce, with a total of 80 (44%) of all participants identifying that they had worked or were currently working as an unregulated health worker (URHW). The primary reason provided for working as an URHW was the need to financially support themselves and their families while obtaining licensure as a nurse in Canada. For many of these participants, employment as an URHW was preferred over other forms of employment as the salaries were higher than other entry level positions that often paid minimum wage.

These findings were consistent with those reported by Covell et al. (2015). Semi-structured interviews with 38 IENs from six Canadian provinces were conducted in this qualitative descriptive study. Participants identified that having access to financial resources was an important facilitator that enabled them to pursue registration. The authors concluded that the availability of economic capital influenced both human and cultural capital, as IENs with financial resources were able to pay the required registration and tuition fees and withstand the time away from the profession to build the necessary capital to integrate into the Canadian nursing workforce (Covell et al., 2015). They further proposed that this conceptualization may help explain why some IENs integrate more successfully than others, as IENs without adequate economic capital may be more vulnerable or need to withdraw from the process of integration (Covell et al., 2015).

This premise was supported by the findings of the current study. Several IENs indicated that they had delayed or suspended their application for RN registration as a result of financial constraints. Furthermore, two of the ten URHW participants noted that they had delayed applying for licensure as either an LPN or RN, as they were unable to afford the fees associated with licensure and bridging education. For participants in this study, economic capital was essential to meet the financial requirements of registration and living expenses while working through the process of integration. When economic capital was limited, financial constraints presented a significant challenge to paying the required fees and affording the high cost of living in Canada.

Social capital and family roles and responsibilities. Social capital is the combination of actual and potential resources that exist as a result of an individual's network of social relationships (Bourdieu, 1986). In previous research, the presence of social capital has been found to have a positive impact on the integration of immigrant professionals into the Canadian workplace (Friesen, 2011; Kelly et al., 2009). Consistent with these findings, social capital was considered an important resource for a number of participants in this study. Family and

friends were identified as the most helpful source of information and support throughout the pre-licensure period. Amongst online survey respondents, family was identified by a total of 82% of participants and friends were identified by 78% of participants as being helpful or very helpful. Family and friends provided informational support about the registration process as well as emotional support to participants as they worked through the licensure requirements. In addition, instrumental support was provided by family and friends through the provision of rent free accommodation to participants when they first arrived in Canada.

Family members were also the primary source of financial support for 15.7% of RN and LPN participants. Not all the support received was provided by family and friends residing in Canada. It was only with the assistance of family and friends residing in the Philippines that some participants were able to obtain the necessary documentation required for licensure directly from the respective organizations within the Philippines. This support, provided by family and friends living in the Philippines, has not previously been identified in the literature on IEN integration in Canada. Thus, this finding identifies the important role of social networks in both the home and receiving country in supporting workforce integration.

Increasingly, the significance of social networks in facilitating the settlement and adaptation of new immigrants has been cited (Brettell, 2015). Networks have been identified as an important source of social capital, connecting migrants to employers or providing information about the labour market. Through networks, migrants can rely on trusted relationships to mitigate some of the risk associated with migration (Bean & Brown, 2015). The findings of this study support the important role of networks in facilitating the process of workforce integration. Amongst participants, the presence of a well-established Filipino diaspora was an important source of support. For example, the Philippine Nurses Association of Manitoba (PNAM) provided workshops for IENs to help them prepare for the national nursing exam. In addition, participants reported that connecting with other IENs while enrolled in bridging programs was a valuable source of support. For example, Angelica had no links to the Philippine community in Canada upon arrival but made helpful connections with other Philippine nurses while enrolled in a bridging program. A total of 71.8% (n=160) of participants indicated that the support they received from other IENs had been helpful or very helpful, and 47.6% (n=166) of participants ranked the support they received from members of the Philippine community as helpful or very helpful.

While family members provided an important source of social capital, the need to support young children and other family members in Canada, while at the same time working through the registration requirements, gave rise to a number of challenges. The responsibility of meeting the financial needs of families resulted in some participants seeking employment in a

'survival job'. As well, participants spoke of the need to delay the submission of an application for RN licensure or attending required bridging education in order to support family members. Sending remittances to family in the Philippines gave rise to additional financial burdens for a number of participants. For one participant, the need to provide care for two young children was provided as the primary reason she was currently not employed in the nursing workforce as a LPN. Amongst participants, just over one half (52.7%) indicated that they had children. Of these, 37.5% reported that their youngest child was of pre-school age and 40.6% stated that their youngest child was of school age. The majority (89.6%) of the children were currently living in Canada (Table 6).

A systematic review of the literature examining IEN migration experiences identified family as a key theme (Moyce et al., 2016); however, the authors noted that only one study included the influence of family responsibilities on workforce integration. "Family First, Nursing Later" (p. 102) emerged as a key theme in the oral history research by Ronquillo (2012). Nine qualitative interviews were held with IENs from the Philippines who arrived in British Columbia or Alberta Canada between 1970 and 2000 (Ronquillo, 2012). The author remarked, "for these nurses, family cohesiveness often took priority over any professional goals they may have had upon arrival in Canada and the need to provide immediate financial support and other familial responsibilities often took precedence" (p. 102).

Likewise, a qualitative study by Atack, Cruz, Maher and Murphy (2012) found that most IENs who were attending a LPN bridging program in Ontario felt pulled in different directions by school, family, and work responsibilities. Finally, a meta-synthesis of the effects of academic bridging programs on IENs described the return to nursing as a form of 'life struggle'. The authors contend that this struggle was rooted in the requirement to complete a bridging program to gain licensure while maintaining multiple roles as partner, parent, and/or relative. With multiple roles came the need to support themselves as well as their families in Canada and/or back home (Cruz, Fellicilda-Reynolds, and Mazzotta, 2017). The findings of the current research were consistent with these earlier studies and highlight the importance of understanding family contexts and how they relate to IEN nursing workforce integration in Canada. To date, only a few studies have examined this phenomena and further research in this area is warranted.

Section Four: The Decision to Work as a LPN or URHW

Practising as a LPN. All of the participants intended to work as a RN when they first migrated to Canada, and the majority of LPNs (78.4%) and URHWs (90%) had applied for licensure with a RN regulatory body at the time the study was carried out. The challenges associated with the RN registration process were identified as the primary reason for choosing to work as a LPN in Canada. Meeting the English language requirements, completing the SEC/CCA, the length of time required to complete the RN licensure process and the costs associated with RN licensure compelled many IENs to seek employment as a LPN. Participants described three different career paths. For some IENs, LPN practice was a stepping stone to RN licensure, others chose to apply for both RN and LPN licensure as a parallel process, and some chose the LPN profession as an alternate career path.

Stepping stone. Bourgeault (2007) proposed that having two different levels of regulatory status, RNs and LPNs, enabled a possible two-step process for integration of IENs into the nursing workforce in Canada. IENs could first enter the workforce as LPNs, which provided them with an opportunity to gain Canadian work experience that would later assist in the process of RN licensure (Bourgeault, 2007). Support for this premise was evident amongst participant responses. A number of IENs noted that they had limited experience as a RN in the Philippines or had no recent experience working in an acute care setting. For these IENs, working as a LPN provided an opportunity to gain experience as a nurse in Canada before pursuing RN licensure. Others reported seeking LPN licensure as a first step for financial reasons. X.V., for example, noted that becoming a RN was her long term goal, but she initially became a LPN, so she could financially support herself and her family while working through the RN licensure process. Thus, working as a LPN provided an opportunity to build both the cultural and financial capital that would facilitate the RN licensure process. Finally, some participants saw LPN licensure as a first step and as a way to gain entry into Canada. Several IENs noted that their initial recruitment as LPNs facilitated their entry into the country, and once established they were then able to take the next step toward RN licensure.

Parallel process. A number of participants chose to pursue RN and LPN licensure at the same time. Several participants noted that applying for both in parallel served as a 'back up plan'; if they were unable to meet the RN licensure requirements, they would still be able to practice as a LPN. In many cases, participants described the LPN registration process as faster and easier, as a SEC/CCA was not required and bridging program coursework was limited.

By applying for both at the same time, IENs would gain LPN licensure first and were able to work as a LPN while continuing to work through the RN licensure process. However, the implementation of a SEC/CCA in 2012 by the College of Licensed Practical Nurses of Manitoba (CLPNM) caused one URHW participant to question if this would continue to be the case. As Imelda recounted, "two weeks ago I received a letter from them [CLPNM] that everyone should undergo a CCA. Somewhat like the RN." While the changes to the LPN licensure process in Manitoba have resulted in delays for some IENs, recent email communication with Jennifer Breton, the Executive Director of the CLPNM, confirmed that based on current IEN applicants, "the parallel process continues to be a popular choice" amongst IENs (J. Breton, personal communication, February 22, 2017).

Alternate career. The SEC/CCA was a notable point of attrition from the RN licensure process amongst LPN participants. Of the 20 LPNs who had applied but were no longer seeking registration as a LPN, 16 reached the stage of completing a SEC/CCA, yet only six continued past this point. Amongst participants, the need to enroll in bridging courses for RN licensure was cited as a key reason for choosing an alternate career as a LPN. Some IENs reported that the required coursework would be too costly and time consuming to complete. Others noted that the outcome of the SEC/CCA revealed significant competence gaps that could not be addressed by bridging, and as a result they did not qualify for RN licensure. Several IENs, anticipating challenges with the RN licensure process, chose not to apply for RN licensure, instead preferring to work as a LPN. Family commitments, financial constraints, and the belief that they would be required to take extensive bridging education led some participants to conclude that an alternate career as a LPN was the best choice. For these IENs, LPN practice provided an opportunity to resume their nursing careers and enter the regulated nursing workforce, with several noting that they felt their qualifications were a good fit for LPN practice.

Limited research in this area has been conducted to date, and at the time this study was carried out no comparative studies were identified. The findings of this study, therefore, provide important insights into the reasons IENs choose to work as LPNs. However, further research is needed if a thorough understanding is to be ascertained.

Working as a URHW. Consistent with the findings of earlier studies (Baumann et al., 2006; Kelly et al., 2009), a number of participants had been, or were currently, employed in the unregulated health workforce in each of the three Prairie Provinces. In addition to the 10 URHWs recruited for this study, 44 of the LPNs and 26 of the RNs who participated in the

online survey had previously been employed as an URHW. The primary reason participants cited for choosing to work as a URHW was the need for a "survival job". The length and cost of the licensure process, the high cost of living in Canada, and the need to provide financial support to family members in Canada as well as the Philippines all necessitated the need to find employment.

Underemployment of IENs and the subsequent brain waste that occurs has previously been identified in the literature (Bourgeault et al., 2010; Kolawole, 2009). One study by Bourgeault et al. 2009 found that 40% of immigrant care workers employed in a long term care setting in Ontario were trained as nurses in their country of origin, and of these, only a few had pursued professional registration in Canada. By contrast, amongst the 10 URHW participants in this study, nine participants had already applied for RN licensure and the one remaining participant planned to pursue professional licensure in the near future. While the URHW participants in this study were evidently underemployed, it is important to note that none of these participants viewed their positions as URHWs as permanent, instead describing them as a means to an end.

Furthermore, participants chose to work as a URHW over other jobs as the remuneration was higher and working in the health field provided an opportunity to build cultural and social capital. Gaining experience in Canadian healthcare as well as establishing connections to employers and other health professionals were cited as key reasons for choosing to work as a URHW. Responses from the online survey data corroborate that these established connections with employers may be helpful in finding employment as a nurse in Canada. A total of one quarter of RN and LPN participants indicated that they had found out about their first nursing position by working in another capacity, as a student, URHW, or volunteer within the facility.

It is important to recognize that the experiences of these IENs may not be representative of the larger IEN community. All of the participants in this study had arrived in Canada within the past five years. Seventy of the IENs who had worked as a URHW had successfully gained licensure as a RN or LPN, and the remaining 10 were still actively seeking licensure. The experiences of IENs who have been in Canada longer, reside in other provinces, or who were unsuccessful in fulfilling licensure requirements may be substantially different. In addition, although working as a URHW was a means to gain financial, social, and cultural capital amongst the participants in this study, this does not negate the need to ensure efficient licensure processes. The need to work as an URHW was necessitated, in many cases, by the length and cost of licensure. A faster licensure process would allow IENs to enter regulated nursing practice faster and lessen the need for an interim survival job.

Section Five: Workforce Profile in Canada

Age and gender. The majority (77.5%) of study participants were female. The largest percentage of RNs (81%) and LPNs (83%) were aged 40 or under. An additional 16.7% of RNs and 10.2% of LPNs were between the ages of 41-49. A small percentage, 2.4% of RNs and 6.8% of LPNs, were over the age of 50. While no direct comparative data were available, in 2013 CIHI reported that amongst IENs in Ontario, 17.2% of RNs and 40.2% of LPNs were early career (under 39), 62.9% of RNs and 50% of LPNs were mid-career (40-59) and 9.9% of RNs and 9.8% of LPNs were late career (over 60). By comparison, amongst all regulated nurses in Canada in 2013, CIHI reported a total of 37.6% of regulated nurses were early career, 50.1% were mid-career, and 12.3% were late career (see Table 53). Therefore, a higher percentage of the IENs who participated in this study were considered early career, as compared to all IENs in Ontario, as well as all regulated nurses in Canada.

Table 53. Age of participants in comparison with Ontario IENs

	RNs	LPNs
Age of Study Participants		
< 40	81%	83%
41 – 49	16.7%	10.2%
50 or older	2.4%	6.8%
IENs in Ontario		
Early Career <40	17.2%	40.2%
Mid- career 40-59	62.9%	50%
Late Career 60+	9.9%	9.8%

(CIHI, 2014a)

Employment status. A total of 57.1% of RNs and 56.8% of LPNs reported that they were working full-time hours at the time the study was carried out. Of those IENs who reported working fulltime, almost 20% indicated that to obtain full-time hours they worked for two or more employers. In order to compare the full-time employment status of participants to other regulated nurses in Canada it was necessary to calculate the number of IENs working full-time with only one employer as this was the definition used by the Canadian Institute for Health Information (CIHI, 2015). Using CIHI's definition of full-time status, a total of 44.3% of LPN

and 47.6% of RN participants worked full-time. By comparison, in 2013, the rates of full-time employment for all RNs and LPNs nationally (Canadian educated and internationally educated) ranged from 48.8% for LPNs to 58.4% for RNs (CIHI, 2014b). Thus, the full-time employment rates for participants from both professions were lower than the national rates; however, the difference was more pronounced amongst RNs.

One third (33.3%) of RN and one fifth (20.5%) of LPN participants in this study reported that they worked part-time. An additional 6% of RNs and 13.6% of LPNs worked in casual positions. By comparison, CIHI reported that amongst all nurses in Canada in 2014, a total of 26.6% of RNs and 37.7% of LPNs worked part-time, while 11.2% of RNs and 13.8% of LPNs worked in casual positions (CIHI 2015a, 2015b). Thus amongst the IENs in the current study, fewer LPN participants worked in part-time positions as compared to all LPNs and fewer RN participants worked in casual positions as compared to all RNs in Canada.

In total, 30.4% of participants working in full-time, part-time, or casual positions reported working for two or more employers. While no Canadian comparative data were available, a study by Spetz, Gates, and Jones (2014) analyzed data from the National Sample Survey of Registered Nurses to characterize the IEN workforce in the U.S. The researchers concluded that a higher percentage of IENs (26.3%) as compared to U.S. educated nurses (12.4%) held more than one nursing job. Working with more than one employer has important implications for IENs integrating into the health workforce. Although similarities in nursing practices exist across employment settings, as Raghuram (2007) noted, considerable variation in nursing practices exist between hospitals and even between units within the same hospital. Accordingly, IENs who work in more than one facility are required to adapt to different work environments with a range of practices and policies, which may present added challenges to overcome. The impact of working for multiple employers on IENs has not been fully explored in the literature to date and would be an important focus for future research.

After obtaining licensure as a regulated nurse in Canada, the majority (87.8%) of participants reported finding their first job as a nurse in under six months. An additional 5.2% secured their first nursing position in six months to one year. Only 4.1% (n=7) of participants were unemployed at the time the study was carried out, all of whom were LPNs. Of the seven LPN participants who were unemployed, five (3%) indicated that they were seeking employment. By comparison, CIHI reported that in 2014 a total of 1.8% of RNs and 3.5% of LPNs were not employed. Amongst LPNs who were not employed, the proportion seeking employment was 3.1% (CIHI, 2015a, 2015b). Thus, the proportions reported amongst participants in this study were similar to those reported for all RNs and LPNs in Canada.

Setting. Amongst the study participants, the highest percentage of both RNs (76.2%) and LPNs (49.4%) were employed in an acute care setting. An additional 14.3% of RNs and 33.3% of LPNs indicated that they worked in either a personal care home or home care setting. Amongst participants, RNs were more likely than LPNs to work in an acute care setting [$p<.001$], and LPNs were more likely than RNs to work in a personal care home or home care setting [$p<.004$].

In 2015, CIHI reported several trends regarding the distribution of regulated nurses by place of employment across Canada. First, hospitals were the primary employer for both professions, employing close to 60% of regulated nurses (CIHI 2015c). Second, hospitals employed a higher percentage of RNs (62.4%) as compared to LPNs (48.5%). Finally, nursing home and long term care facilities employed a higher proportion of LPNs (31.5%) than RNs (8.8%) (CIHI, 2015a, 2015b). All three of these trends were reflected in the findings of this study.

CIHI (2014) data on place of work for IENs in Ontario revealed that amongst both RN and LPN professions, a higher percentage of IENs worked in long term care settings as compared to Canadian educated nurses. Amongst RNs, 15.8% of IENs worked in long term care as compared to 7.2% of Canadian educated nurses. For LPNs, 53.9% of IENs versus 36.3% of Canadian educated nurses worked in long term care (CIHI, 2014a). Similarly, Spetz et al. (2014) reported that IENs from the Philippines and India were more likely to work in nursing homes than U.S. educated nurses. Amongst the study participants, the percentages of IENs working in long term care settings were higher than for all regulated nurses across the country. However, the percentages were lower (particularly for LPNs) than those reported for IENs in Ontario.

For a number of the IENs in this study working in a long term care setting presented challenges. Some participants described a loss of nursing knowledge and skills associated with working in a nursing home. These nurses, having worked in an acute care setting pre-migration, felt overqualified to work in long term care. By contrast, other participants recognized gerontological nursing as a specialized practice and felt inadequately prepared to work with elders. Nicole, for example, explained that her nursing program in the Philippines had placed little emphasis on gerontology and elder care, and as a result she felt her knowledge base in this area was limited. The ageing of the world's population is expected to create a growing demand for nurses qualified to work in geriatric settings (Carlson, Rämgård, Bolmsjö, & Begtsson, 2014). To meet this demand, an increasing number of IENs who migrate to Canada will likely be employed in long term care settings. A lack of knowledge in geriatric care has been linked to increased risk to patient safety (Wagner & Rust, 2008). Thus, ensuring

IENs have access to educational resources on the key concepts of gerontological nursing is key.

Intention to stay. The majority of IENs (41% RNs and 47% of LPNs) intended to stay with their current employer for an additional 1-5 years. A total of 21% of RNs and 17% of LPNs reported their intention to stay with their current employer between 6-15 years or "many more years," and an additional 25% of RNs and 20% of LPNs indicated they would like to stay with their current employer for 16 or more years or until retirement. Given current and projected shortages in the supply of regulated nurses worldwide, turnover rates are gaining increasing attention (Duffield, Roche, Horner, Buchan, & Dimitrelis, 2014). In Canada, the turnover rate amongst all regulated nurses has been estimated at 19.9% (O'Brien-Pallas, Murphy, Li, & Hages, 2010). As IENs comprise approximately 8% of the regulated nursing workforce in Canada (CIHI 2017), understanding the factors that lead to both retention and turnover amongst this group of nurses as well as how the turnover rates of IENs compare to Canadian educated nurses are important to inform workforce planning.

Perceived employment match. IENs described the match between their pre-migration education and work experience and their current employment from two perspectives: their professional status as a RN or LPN or the employment setting where they were currently employed. IENs provided varied responses, with some reporting a good match, while others thought they were over or underqualified for their current positions. To date, no other research studies have been found examining this concept. These findings, therefore, provide an important perspective.

The majority of RNs felt their current employment in Canada was a good match for their education and pre-migration work experience. While some felt their entry level nursing education had adequately prepared them to practice as a RN in Canada, others noted the importance of attending bridging education to address gaps in knowledge or skills and to orient them to Canadian nursing practice. A number of LPNs also reported that their current nursing practice was a good fit. LPNs who felt they were able to fully utilize their knowledge and skills, for example IENs employed in dialysis or other specialty units, as well as IENs with limited pre-migration work experience were amongst those LPNs who felt their qualifications were a good match. For these IENs, LPN practice provided an opportunity to continue their nursing careers in Canada.

Not all IENs felt their current employment was a good match for their pre-migration education and work experience. Some LPNs noted that their entry level nursing education in

the Philippines was at the Baccalaureate level and felt overqualified for their current practice as a LPN. Similarly, a few RNs employed in a long-term care setting did not feel they fully utilized their nursing knowledge and experience. By contrast, a few LPNs as well as RNs felt underqualified to practice in certain settings. For example, P.N. felt underqualified to work in a specialty unit and G.Q. reported feeling overly stressed working in an acute surgical area.

The issue of mismatched skills as it relates to Philippine professionals who migrate to Canada has previously been discussed in the literature (Kelly et al., 2009). As all participants had initially been educated as RNs in the Philippines, the employment of IENs as LPNs in Canada could, at face value, be interpreted as downward professional mobility. However, the findings of this study suggest that the IENs' perception of the match between pre-migration qualifications and post migration employment was more complex and could not be solely described in relation to their professional status as RNs or LPNs. The level of acuity and/or the responsibilities associated with the employment setting as well as the amount of prior work experience the IEN possessed were also considerations for participants. Consequently, some RNs as well as some LPNs perceived a good match, while others felt over or underqualified for their positions. The diversity of responses suggest that IENs perceive the match between pre-migration qualifications and post migration employment differently, and further research is needed to explore this concept more fully.

Summary. These findings suggest that IENs from the Philippines constitute a valuable component of the nursing workforce in Canada as RNs and LPNs. Amongst the IENs in this study, the majority reported that they worked full-time and many indicated their intention to stay with their current employer for an extended period of time. IENs were employed in a variety of settings, with the majority working in acute and long term care environments. Furthermore, while the sample population of IENs was small and may not be representative of all IENs from the Philippines who migrate to Canada, the high percentage of early career nurses reported in this sample was of note. These IENS have the potential to remain in the workforce for many years; therefore, investing resources to support their integration could have long term benefits on health human resources.

Section Six: Working as a Nurse - Challenges and Resources

Building embodied cultural capital. Embodied cultural capital is deeply internalized and not consciously known (Bourdieu, 1986). A 'professional habitus' is developed through shared perspectives, norms, and practices, and develops as a result of socialization processes defined within the contexts in which professionals are educated and work (Mendoza et al., 2012). Embodied cultural capital is acquired over time and is evident when IENs possess an understanding of the social norms, values, and language of the host country (Covell et al., 2015). The acquisition of cultural capital and the need to redefine one's professional habitus emerged as a prominent theme in this research. A number of participants described the challenge of developing different sociocultural language and communication skills, the need to adapt to different professional roles and responsibilities, and the internal conflicts that arose while working within a health care system where the underlying values, at times, differed from their own.

Sociocultural language skills. During the qualitative interviews a number of participants noted that the high English language scores required pre-licensure provided them with the technical language skill needed for the workplace. Similarly, the online survey responses revealed that only 3.6% of RNs and 7.5% of LPNs agreed or strongly agreed that communication in English was difficult. Although the majority of participants described few challenges with technical language skills, a number of challenges with the sociocultural aspects of communication were reported.

First, understanding idioms and learning how to address patients and their families in a culturally respectful manner took time. Participants described the challenge of conversing with patients or family members about their health or plan of care. Without a shared language or culture, IENs found it difficult to communicate in a manner similar to Canadian educated nurses. Adding further complexity, IENs described difficulty working in a multicultural environment and identified challenges understanding the different accents of patients and colleagues from different language backgrounds. Online survey responses revealed that 31.3% of RNs and 32.6% of LPNs strongly agreed or agreed that the different accents encountered in the work setting were difficult to understand.

These findings lend support to a growing body of literature that highlights the importance of both technical and sociocultural language skills in the practice of nursing. To facilitate successful workforce integration, IENs with English as an additional language (EAL) must

first meet the required language levels in reading, writing, listening, and speaking, but it is becoming increasingly evident that technical language alone is not adequate. IENs must also learn the communication skills specific to the social and cultural context of the profession (Allan & Westwood 2016; Kawi & Xu, 2009; Lum, Dowedoff, Bradley, Kerekes, & Valeo, 2015). As Lum et al. (2015) contend, the nursing profession has a "complex, highly developed practice culture and language system" (p. 86). This system contains phraseology, acronyms, terminology, and informal jargon that may be unclear to language learners from different cultures. IENs might be experts in clinical practice but may lack the social and interpersonal aspects of communication important in workplace interactions (Lum et al., 2015). These sociocultural communication skills include the ability to engage in small talk (Holmes & Major, 2003), jokes, euphemisms, and non-verbal behaviours (Kawi & Xu, 2009), as well as the ability to adjust their language in order to suit the purpose and context (Lum et al., 2015). Consistent with the findings of this study, Lum et al. (2015) also note that many IENs who have previously worked in a culturally homogenous environment find it difficult to work with the culturally diverse patient population found in many Canadian health care settings.

Second, consistent with the findings of previous research (Lum et al., 2015; Tregunno et al., 2009), a number of study participants expressed difficulty with assertive communication when first employed as a nurse in Canada. For example, assertive communication was a challenge for Anna who described feeling shy and timid when she first began working as a RN, and Hannah explained how she was initially teased for being "too polite" when communicating with physicians. Similarly, online survey responses indicated that for some participants assertive communication with other health professionals was difficult. RN and LPN participants reported difficulties with assertive communication with doctors (20%), nursing colleagues (17%), interdisciplinary team members (14.5%), and URHWs (14%). Earlier research by Cummins (2009) reported similar challenges with assertiveness. IENs reported difficulty with assertiveness toward their nursing colleagues (14%), medical colleagues (24%), and ancillary staff (18%).

Third, difficulties with delegation were also reported. A number of interview participants described challenges with delegation in the early stages of employment. For example, Victoria told of the challenges she had initially encountered delegating tasks to URHWs with years of experience until she learned to "stand her ground," and Jeffrey described how, in his first nursing position, he felt bullied and disrespected by experienced URHWs when he tried to delegate work to them. In addition, survey responses revealed that approximately one fifth (21.7%) of RNs and LPNs disagreed or strongly disagreed that delegating to other nurses was easy, and 20% disagreed or strongly disagreed that delegating to URHWs was easy. These

results were consistent with those reported by Cummins (2009), where a total of 25% of IENs disagreed or strongly disagreed that delegating to other nurses was easy, and 21% disagreed or strongly disagreed that delegating to ancillary staff was easy.

Finally, participants in the current study commented that patients and families in Canada were more involved in decision making than in the Philippines. For IENs, the transition from a health care system where physicians and nurses were considered the authority and primarily directed care to an environment where family and patient involvement was encouraged and supported was difficult. This finding was consistent with those reported by Tregunno et al. (2009). Thirty IENs from 20 different countries were interviewed, and differences in the expectations of patients and family in Canada emerged as a key theme. Ontario patients and families were seen by IENs to be more knowledgeable, have more rights, and be more involved with decision making than those in their home countries (Tregunno et al., 2009). Understanding the role of the patient and family in a client-centered model of care is an important component of the social and cultural communication skills required by IENs to communicate effectively in a Canadian practice setting (Lum et al., 2015).

Professional roles. During the qualitative interviews both RN and LPN participants described differences in the roles and responsibilities of regulated nurses in Canada as compared to the Philippines. Participants commented that nurses in Canada have more autonomy and an expanded scope of practice. In the Philippines, physicians had a greater presence on the units and assumed more responsibility for decision making, whereas in Canada physicians were not always present and nurses had to assume greater independence in clinical decisions. Participants also described the collaborative nature of practice in Canada and the importance of working with members of the interdisciplinary team. While some participants found this adjustment stressful, others noted that they liked being "listened to" and having their input valued by other health professionals.

These findings were consistent with previous research. Differences in the level of autonomy, clinical decision making, and the role of the nurse have been reported by IENs in a number of studies (Blythe et al., 2009; Lin, 2009; Xiao, Willis, & Jeffers, 2014). A recent systematic review conducted by Moyce et al. (2016) identified differences in scope of nursing practice as a major theme in the literature on the migration experiences of IENs. Similarly, an integrative review on the experiences of IENs in the U.K. revealed that differences in the nursing role was a main theme that emerged (Nichols & Campbell, 2010).

Role ambiguity regarding the scope of practice of LPNs as compared to RNs in Canada emerged as a key issue for a number of LPN participants. LPNs primarily described their

scope in terms of the specific nursing skills they could or could not perform. For example, participants remarked that as LPNs they could not give certain medications or administer blood transfusions. Recent expansion of the number and types of skills LPNs were authorized to perform led several participants to describe the differences between RN and LPN practice as minor and the roles and responsibilities of both professions as similar. Any differences in roles were described from a functional nursing perspective (nursing tasks) and the increased level of knowledge and critical thinking attached to the RNs' responsibilities were rarely acknowledged.

The role ambiguity described amongst the internationally educated LPN participants in this study has also been reported amongst Canadian educated LPNs. Besner et al. (2005) explored the extent to which RNs, LPNs, and Registered Psychiatric Nurses (RPNs) in Alberta and Saskatchewan were able to work to their full scope of practice. The researchers concluded that there was considerable role confusion amongst the three groups of regulated nurses, and participants were unable to clearly articulate the differences in their roles. Similar results were reported by Lankshear, Rush, Weeres, and Martin (2016), who conducted a mixed methods study with 1101 RNs and LPNs in Ontario. Participants reported varying levels of knowledge regarding both the distinct and overlapping aspects of scope of practice between the two nursing professions, and as with the participants in the current study, many of the nurses described their scope of practice in terms of what they 'do' or 'perform' in their daily work, rather than referencing the knowledge base of the profession. The authors contend that changes in education, regulation, and legislation have drawn attention to the blurring or overlap in RN and LPN roles. With continuing changes to scope of practice it will be important to address issues of role ambiguity regarding LPN practice in a formal manner: "The potential implications for not focusing on the role clarity/ambiguity issues of PN practice in a formal manner may hold the potential for negative impact at levels of the patient (eg, patient safety), nurse (eg, role satisfaction), and the health system (eg, availability of the right provider, providing the right care)" (Lankshear et al., 2016, p. 306).

Differing values. During the qualitative interviews participants discussed the challenge of working in a health care system that espoused different, and at times, conflicting values to their own. Participants identified three main areas where values differed: the nurses' sense of duty, the approach to pain management, and the philosophy of end of life care.

Sense of duty. Differences between the 'sense of duty' espoused by nurses in Canada as compared to nurses in the Philippines were described by participants. Canadian nurses were perceived as "time oriented" in regards to their scheduled hours of work, ensuring scheduled

breaks were taken and leaving work on-time at the end of their shift. Whereas nurses from the Philippines were perceived as possessing a greater sense of duty, staying late and missing breaks to ensure all their work was completed. Ortiga (2014) interviewed 58 teachers and administrators employed in nursing schools in the Philippines. The author concluded that for the majority of participants their professional values were consistent with the Nightingale era where nursing was a calling and nurses were required to be altruistic and inherently caring. The comments above confirm that similar values were held by a number of the participants in this study. Nursing was seen as a vocation and nurses' sense of duty was important.

However, not all participants shared these values. While some participants described the Canadian nurses' work ethic with some derision, others preferred Canadian practices with clearly defined hours of work and assigned breaks. For these participants their values were consistent with Canadian nursing practice. Victoria, for example, described a sense of belonging in Canada: "Yeah, I guess I belong here in Canada, not in the Philippines." This difference in values amongst participants was an important finding. IENs are often described in the literature as one homogenous group, yet this finding demonstrates that individual differences exist, even amongst IENs from the same country. Understanding and respecting these differences is an important consideration in designing programs and supports that can be tailored to individual needs.

Pain Management. Differences in the approach to pain management in Canada as compared to the Philippines were also discussed by a number of participants. Cultural differences in pain tolerance, the priority given to the clients' subjective interpretation of pain, and the frequent use of narcotic analgesics in Canada to manage symptoms were amongst the differences cited. Furthermore, the provision of palliative care to patients in the final stages of a terminal illness created a moral conflict for some participants who felt it was contrary to their religious or cultural beliefs. This was best described by Hannah. She explained her struggle following a care plan that focused on making a patient comfortable and "no heroic measures" were to be undertaken. In her words:

> "I said I am a Filipino and we have a very different view about life and if we can extend life even just for a day, umm we try to, so I think it's cultural – it's a cultural issue that I'm struggling with since I've started. We respect that, we provide the care that the resident needs, we make them comfortable, we support the family, it's just hard."

End of Life Care. Nishimoto and Foley (2001) conducted a review of the literature on the cultural beliefs of Asian Americans associated with end of life care. The authors noted that amongst those Filipino Americans who believed that the future was in God's hands, there was, at times, a reluctance to sign advanced directives or submit to palliative care as it would "take the decision out of God's hands" and would therefore "not be acceptable to their belief system" (Nishimoto & Foley, 2001, p. 180). This conflict between personal beliefs and the end of life care philosophy was evident amongst participants in this study.

This experience of moral conflict has not previously been discussed in the literature specific to IENs; however, the concept of moral distress has been widely examined in the broader nursing literature. Moral distress is the psychological response that occurs when individuals feel morally constrained (Fourie, 2015) as a result of either individual (internal) or workforce (external) constraints (Hamric, 2000). A recent study by Bressler, Hanna, and Smith (2017), explored the concept of moral distress amongst U.S. nurses working with Orthodox Jewish patients at the end of life. The findings revealed that conflicts of values among health professionals, patients, and families could create the experience of moral distress. Consistent with the findings of the current study, Bressler et al. (2017) reported that differences in values between nurses and the families about the goals of care were identified by nurses as a source of conflict. Nurses understood and respected the patients and families right to treatment in accordance with their beliefs and values but reported experiencing internal conflict from participating in care contrary to their own beliefs.

Employer supports: Orientation and preceptorship. Employee orientation programs were identified as an important source of support for IENs transitioning to Canadian nursing practice. Amongst RN and LPN participants 62.8% rated hospital orientation as very helpful and an additional 27.4% rated orientation as quite helpful in assisting with their adjustment to their first nursing position in Canada. Information on hospital policies and procedures as well as specific protocols (cardiac care, for example) were cited as valuable components to include in orientation sessions. IENs also identified challenges working with different resources. Including information on the equipment and technologies utilized as well as how nursing care is organized within the facility, would therefore be helpful.

Although orientation was considered helpful by the majority of participants, the duration of orientation programs varied considerably amongst employers, ranging from several months to a few days. Participants who had received minimal orientation reported that additional training would have been helpful. Similar variability in the length and content of hospital

orientation programs provided to IENs upon employment in Canada was noted by Neiterman and Bourgeault (2015).

The benefit of a preceptorship, where an experienced nurse (preceptor) supports a newly qualified nurse in order to ease their transition into professional nursing practice (Higgins, Spencer, & Kane, 2010), was identified as an important support to facilitate workforce integration. Working with a preceptor when first hired was considered very helpful (65.9%) and quite helpful (26.2%) by both RN and LPN participants. Amongst interview participants the number of shifts assigned to work with a preceptor varied from a period of two months to just a few days. Although the majority of participants cited "buddy shifts" as the most helpful source of support while transitioning to nursing in Canada, for many, the number of shifts were considered insufficient. IENs who had spent just a few days assigned to a preceptor, as well as those assigned to work with a preceptor for over a month, similarly commented that they would benefit from additional shifts.

The important role of preceptors in supporting the transition of newly qualified nurses has been well documented in the literature (Higgins, Spencer, & Kane, 2010). Similarly, the presence of preceptors has been identified as one of the key factors in supporting the successful adaptation of IENs into the nursing workforce (Zizzo and Xu, 2009). Zizzo and Xu (2009) conducted a systematic review of the literature on transitional programs for IENs, and of the twenty studies reviewed, nine included the use of preceptors or mentors as a component of adaptation programs. IENs in one Ontario study remarked that working with a preceptor provided an opportunity to practice safely under supervision, which had increased their self-confidence (Atack et al. 2012). As well, Riden, Jacobs, and Marshall (2014) noted that RN preceptors in New Zealand provided support to IENs in four key areas: assessing clinical skills, teaching clinical skills, teaching the culture of nursing practice in New Zealand, and emotional and spiritual care.

Attitudes of others. The environment of the workplace, whether positive or negative, had an impact on the experiences of participants as they integrated into the nursing profession. The majority of participants reported that the support they received from other nurses was helpful in facilitating their adaptation to nursing in Canada. A total of 94.5% of participants indicated that other nurses were quite or very helpful and the majority of participants agreed or strongly agreed that their work colleagues understood (55%) or considered (56%) their cultural perspectives. Likewise, managers were considered quite or very helpful by 86.4% of participants and hospital educators were considered quite or very helpful by a total of 79.8% of participants (Table 52).

However, not all nurses were reported to be supportive toward IENs. A number of participants provided examples of times when colleagues had refused to provide needed assistance or engaged in bullying behaviours toward them. Gerrish and Griffith (2004) reported similar findings. The authors evaluated an adaptation program for IENs in the U.K. While the majority of British nurses were supportive, a minority were hostile toward the IENs. The authors concluded that much of the success depended on the ward 'atmosphere' (p. 583), and integration was facilitated when the nursing staff were approachable and supportive. A more recent study explored the perceptions of managers of the experiences of racism and discrimination toward African nurses working in the National Health Service in the U.K. The researchers' found that African nurses were at times bullied, undermined, and called names by their white colleagues (Likupe, 2015). Likewise, Xiao et al. (2014) reported that while the majority of Australian nurses were supportive toward IENs, the unsupportive behaviours of some nurses created a barrier that impacted group cohesion and the subsequent integration of IENs into the nursing workforce.

While some participants felt these unsupportive behaviours were directed primarily toward IENs, others felt they targeted all novice nurses and new Canadian graduates were treated in a similar manner. Horizontal hostility, a type of bullying that can be expressed in overt behaviours, such as fault finding or intimidation, or covert behaviours, such as refusal to help or work with someone, has been described amongst newly qualified nurses (Bailey, 2013). Limited work experience and developing nursing knowledge are key reasons new graduates were vulnerable to horizontal hostility (Griffin, 2004). Horizontal hostility has been linked to anxiety, depression, lower job satisfaction, higher turnover rates, and absenteeism (Hauge, Skogstad, & Einarsen, 2010). In addition, insulting, rude, and disrespectful behaviours have been identified as potentially increasing unsafe practices (Hughes, 2008) and increased horizontal hostility scores have been correlated with poor patient outcomes (Reynolds et al., 2014).

Potential risks to patient safety were similarly reported by participants in the current study. For example, rather than intervening to provide assistance and prevent an error from occurring, Christina described how staff members allowed her to make a mistake and then reported her to the manager afterward. Similarly, Isaak remarked that in some cases staff were more concerned with documenting his error after it occurred, rather than preventing the error from occurring in the first place. These findings highlight the importance of creating a positive work environment, where IENs feel supported, to promote the delivery of safe patient care.

Racism and discrimination. Consistent with previous research, both racist attitudes and discriminatory practices toward IENs were reported by study participants (DiCicco-Bloom, 2004; Gupta, 2009; Jones et al., 2009; Kawi & Xu, 2009; Kingma, 2008a; Likupe, 2015; Moyce et al., 2016; Wheeler, Foster, & Hepburn, 2014; Winkelmann-Gleed & Seeley, 2005). Both RN and LPN participants agreed or strongly agreed with the statements that their race, ethnicity, or colour had an effect on their hiring (20.2%), where they worked (22.7%), training opportunities (23.8%), and performance reviews (22%), as well as relations with their managers (21.5%), patients (23.8%), and colleagues (24.5%). Likewise, Gupta (2009) reported that amongst Asian nurses the percentage who reported that their race, ethnicity, or colour had an effect on their employment ranged from a low of 22.2% (performance reviews) to a high of 50% (hiring). Tregunno et al. (2009) also found that IENs in Ontario encountered racism and aggression in the workplace and shared experiences of being 'treated as the other' (p. 187) by patients, families, and coworkers.

The qualitative comments by a number of RNs and LPNs described how they felt the need to prove their level of knowledge to their colleagues or that their colleagues took advantage of them by assigning unwanted tasks. These remarks were consistent with those reported by Tregunno et al. (2009), where IENs perceived a lack of trust toward them in the workplace and their non IEN colleagues were seen to make quick judgments about the adequacy of their nursing qualifications. Likewise, Gupta (2009) found that nurses of colour felt that their white colleagues did not fully recognize their knowledge and abilities. Gupta (2009) suggested that this attitude could lead to serious consequences such as formal complaints or lack of promotion opportunities and is based on "age-old racist ideologies about people of colour being incompetent and inferior compared to white people" (p. 74).

Amongst the URHW participants, the results were similar to the RN and LPNs in hiring (20%), where they work (30%), and training opportunities (20%). Higher numbers of URHWs, one half (50%) of participants, reported that their race, ethnicity, or colour had an effect on their relations with their managers and their colleagues, and 90% perceived that these factors had impacted their relations with patients. The racist attitudes of some patients were particularly evident in the qualitative data, where participants provided examples of derogatory, intolerant, or racist remarks made toward them. While the sample size of URHW participants was small (n=10) and the results must be interpreted with caution, the high number of URHWs who reported racism or discrimination during interactions with clients, colleagues, and managers is of considerable concern and worthy of further study.

Baptiste (2015) conducted a review of the literature on IENs and workforce discrimination and concluded that discrimination acts as an additional workplace stressor for IENs who are

adapting to a new work environment. Discrimination affected the IEN's sense of well-being, job satisfaction, and turnover rates as well as the quality of patient care. The author contends that it is necessary to educate all health care providers on discrimination and the consequences of discriminatory behaviours on the IEN, the work environment, and patient care (Baptiste, 2015).

Participants also voiced concern that RNs from the Philippines were referred to the SEC/CCA more often than IENs from other countries, leading a small number to question if the referral for assessment was discriminatory, while others thought it was a reflection on the value (or undervalue) awarded their education. The perception of under-recognition of credentials as a form of discrimination has been reported in earlier studies. Eric (2012) interviewed 16 Filipino IENs from two cohorts: those who arrived in the 1960's and 1970s and those who have migrated since the late 1980s. Integration appeared easier for the earlier cohort, as the later cohort reported a number of additional challenges. For example, one participant, enrolled in courses toward LPN licensure, felt the 'downgrading' of her Filipino nursing credentials was discriminatory. Similarly, Taylor et al. (2011) note that the process of RN licensing in Alberta was particularly difficult for IENs from the Philippines and raised concerns about cultural bias.

Summary. In addition to educational qualifications and work experience, in order to integrate into the Canadian nursing workforce IENs were required to build embodied cultural capital. Sociocultural language and communications skills as well as an understanding of professional nursing roles in Canada were needed. Within the health care environment, a number of IENs also encountered differing values, and aligning these values with their own was perceived as a challenge for some participants. Racism, discrimination, and negative attitudes of others were further challenges experienced while integrating into the nursing workforce. Employer supports, such as orientation and mentorship, along with the supportive attitudes of colleagues were identified as helpful supports to facilitate integration.

Chapter Six: Conclusion

This study explored and described the integration of IENs from the Philippines into the nursing workforce in the Canadian Prairie Provinces. In this final chapter, a written and visual summary portraying the nursing workforce integration of participants will be presented. In addition, the strengths, limitations, and implications of the study findings will be discussed.

Nursing Workforce Integration in the Canadian Prairie Provinces

The conceptualization of workforce integration presented in chapter two (Figure 2) depicted integration as a two way process whereby IENs possessed the necessary cultural, social, and financial capital, and in turn the host society supported integration through policies, supports, and services accessible to IENs. The findings of this study support this premise. IENs arrived in Canada with institutionalized cultural capital in the form of educational credentials and work experience, along with varying levels of financial, social, and embodied cultural capital. IENs who possessed the necessary capital, for example, they met the required English language levels for registration, were able to utilize this capital toward entry into a regulated nursing profession in Canada. For those IENs who did not possess the necessary capital, for example, embodied cultural capital had to be acquired or gaps in knowledge or skills were identified during the SEC/CCA, bridging programs and other resources were provided by the host society to build the required capital and support workforce integration. In this way, the attributes of both the IEN and the host society were instrumental to the successful integration of IENs into the nursing workforce in Canada.

The original conceptualization also depicted the IEN and host society factors as operating in parallel with each strand independent. However, the experiences described by participants in this study revealed that both the IEN and host society characteristics were interrelated. As conditions within Canada changed, the capital required by the IEN also changed. This interrelation is best illustrated by examining how changes to the regulatory requirements altered the cultural and financial capital needed by IENs to become registered as RNs in Canada. In 2011, based on recommendations brought forward by the National Fluency Working Group, all RN regulators in the Prairie Provinces harmonized their English language requirements and adopted a higher English language proficiency level (CRNM, 2012). As a result, IENs who applied for licensure after the change was implemented required a higher level of linguistic cultural capital than IENs who had applied prior to the implementation of the new requirement. To attain the higher language score, participants described having to

enroll in additional English language classes and reported the need for increased financial capital to cover tuition fees and cost of living expenses while meeting the new registration requirements.

The introduction of the SEC/CCA had a similar impact. After the competence assessment had been implemented in 2009, the value ascribed to the institutionalized cultural capital of IENs was based on the outcome of the assessment. While some IENs possessed the necessary competence to proceed to the final stage of registration, others were required to address knowledge and skill gaps through participation in bridging education. For these participants the introduction of the competence assessment increased the financial capital required to attain licensure as they were confronted with the additional costs of tuition, as well as time away from work and the need to cover daily living expenses while attending classes.

Arguably both these policy changes were implemented to ensure IENs possess the necessary competencies for nursing practice in Canada. However, it is important to recognize the impact these changes have on other parts of the system. Changes to the regulatory requirements altered the cultural and financial capital needed by IENs to become registered as RNs in Canada. This in turn influenced the host society resources required to support integration. In some cases, the regulatory policy changes, designed to support successful integration, acted as a barrier as IENs reported challenges accessing the necessary language and bridging programs.

A critical realist perspective views reality as an open system with many interacting structures and mechanisms (Harwood & Clark, 2012). Through this lens, context is an important consideration, as outcomes vary across different circumstances (Bhaskar, 1975; Frauley & Pearce 2007; Wynn & Williams, 2012). Integration into the Canadian nursing workforce began with the decision to migrate and the ability to gain entry into Canada. At the time this research was carried out, the demand for nurses in the Prairie Provinces was an important contextual factor. Active recruitment campaigns as well as government policies that awarded IENs additional points on their immigration applications facilitated entry into the country for many participants. The demand for nurses also created a favourable job market and once licensed, the majority of IENs found employment as a regulated nurse in under six months. However, it is important to recognize that context is dynamic, and as conditions change (for example, a decrease in the demand for RNs), the experiences of IENs integrating into the Canadian nursing workforce may also change.

Contextual factors also varied amongst individual IENs. For example, the ability to access government programs and support differed depending on the IEN's immigration status (permanent resident or TFW) upon arrival to Canada and the experiences of IENs who entered

a supportive work environment differed from those who encountered negative or racist attitudes. IENs who lived in rural settings reported difficulties accessing bridging education as the majority of programs were offered in urban communities, while participants with family roles and responsibilities described added financial challenges that, in some cases, delayed or prevented them from seeking RN licensure. In each of these examples, the participants' experiences with workforce integration were situated within a particular context. Contextual factors varied and subsequently differing experiences were reported. In some cases the amount of capital required as well the accessibility and availability of resources changed with differing conditions.

Figure 12 provides a visual depiction of nursing workforce integration as described by the findings of this study. The ease of entry into the country along with individual motivations for migration brought IENs to Canada. Once in Canada, the capital the IEN possessed as well as host country resources were required to facilitate nursing workforce integration. Finally, experiences with integration and the resources required were situated within the wider context and varied amongst IENs.

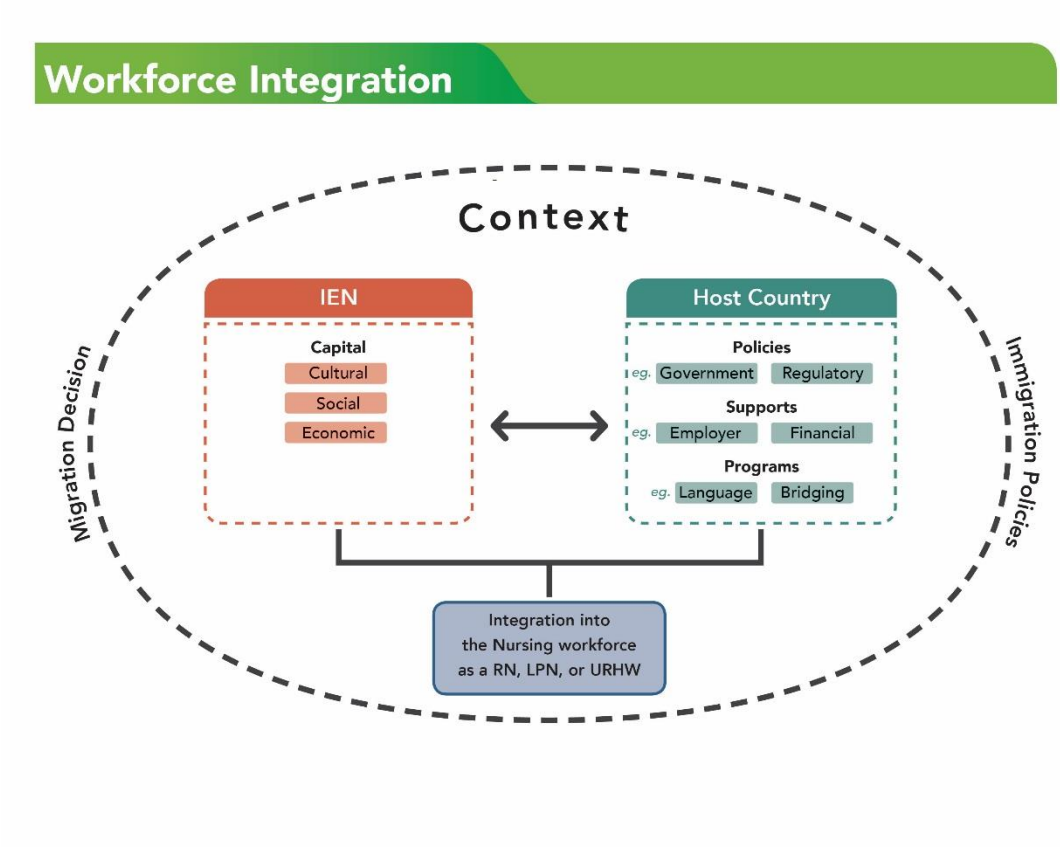

Figure 12. Workforce integration.
Source: Author

Methodological Considerations

Limitations. A nonprobability sample of 172 RN and LPN participants completed the online survey. At the time this study was carried out, data were not available to confirm the total number of IENs from the Philippines who met the eligibility criteria; therefore, the percentage of the total population this sample represents could not accurately be ascertained. This, combined with the use of nonprobability sampling techniques, limits the generalizability of the study findings (Polit & Beck, 2016). While the results of this study add to the understanding of the experiences of IENs from the Philippines as they integrate into the nursing workforce in the Prairie Provinces, the findings may not be representative of the experiences of other IENs and therefore, must be applied to other contexts with caution. Furthermore, the non-parametric statistical tests used to analyze the quantitative data were less powerful than their parametric equivalents. As a result, the possibility of making a type II error was higher, and significant differences between RN and LPN groups may not have been detected (Hassard, 1991).

Strengths. The use of a mixed methods design allowed the researcher to seek complementarity, expansion, and triangulation of the data collected, and the subsequent findings reflected a more complete description of the phenomena than if either a quantitative or qualitative approach had been utilized alone. The distribution of an online survey provided a cost effective and efficient way to obtain data from a large sample of IENs, while the qualitative interviews yielded rich in-depth qualitative descriptions that could be interpreted alongside the quantitative findings. Finally, the inclusion of only one population of IENs, RNs from the Philippines, provided important insights into the nursing workforce integration experiences of the largest group of IENs in Canada.

Implications for Bridging Education, Employers, Policy, and Research

The findings of this research gave rise to a number of considerations. Bridging education, employer supports, as well as government and regulatory policies all play an important role in the integration of IENs into the nursing workforce. Aligning policies and resources to facilitate integration is important. The following section will highlight the implications in each of these domains and will conclude with a discussion on areas for future research.

Implications for bridging education. The findings of this study lend further support to the value of bridging education as a means to address gaps in knowledge and skills. Consistent with other research, IENs identified the need for additional knowledge in the areas of health assessment and gerontology (Atack et al., 2012). Participants also described differences in medication administration, technology, and equipment, as well as reported challenges with adjusting to the professional roles, scope of practice, values, and philosophies of nursing practice in Canada (Atack et al., 2012; Tregunno et al., 2009). For many participants the opportunity to gain clinical practice experience in a Canadian health care setting was considered the most valuable component of bridging education. Inclusion of content to address these identified knowledge gaps as well as the provision of adequate clinical practice time are important components of bridging program curriculum (Atack et al., 2012).

Bridging programs are also well suited to develop the sociocultural language and communication skills required for the successful transition of IENs into the nursing workforce (Atack et al., 2012; Lum et al., 2015). Assertive communication, delegation, therapeutic communication with patients and families, and inter-professional communication were all identified challenges amongst IENs in this research. By incorporating professional social and cultural language learning into the program design, bridging programs can provide opportunities for both knowledge and skill development in the sociocultural aspects of nursing practice and can provide IENs with additional time to develop and practice these skills in a supportive educational environment (Lum et al., 2015).

Furthermore, bridging programs are well positioned to address role ambiguity by including content on the scope of practice of both RNs and LPNs in Canada. The differences in RN and LPN scope of practice have been outlined in a number of documents in recent years (CNA, 2015; CNO, 2014; Nurses Association of New Brunswick & Association of New Brunswick Licensed Practical Nurses, 2015). Incorporating this information into bridging program curriculum is important. IENs work as both RNs and LPNs in Canada; clearly articulating the roles and scope of practice of each of the nursing professions will help provide role clarity and optimal collaboration between professions (Lankshear et al., 2016).

The cost and accessibility of bridging education was an identified challenge amongst participants. Increased access to bridging education in both rural and urban settings, affordable tuition, and flexible programming are important design considerations. In addition, a few IENs who had undergone a SEC/CCA and were not required to complete a bridging program expressed a desire to access bridging courses on a voluntary basis. Given this interest in self-referral, revision of current admission policies for bridging programs to allow a select number of seats for elective students may address an identified need.

Implications for employers. The findings of this research highlight the importance of providing an adequate orientation period for IENs. Orientation programs, as well as extended time working with a preceptor, were helpful resources that supported IENs as they integrated into the workforce. However, significant variation in the types and amount of orientation provided to IENs was present amongst participants. Providing additional training for preceptors, along with the development of a standardized orientation program designed specifically to address the needs of IENs and shared amongst employers would be advantageous. Furthermore, reports of racist attitudes and bullying behaviours toward IENs underscore the need for additional education alongside the development, implementation, and enforcement of workplace policies that denounce these negative attitudes and behaviours. Although respectful workplace policies already exist in many settings, continued reports of racism, discrimination, and bullying, albeit by a minority of health professionals, informs us that further work needs to be done.

Implications for immigration policy. The recent shifts in immigration policy toward higher numbers of TFWs raises concern. The experiences of a number of participants in this study suggest that policy shifts that favour increased numbers of temporary entrants may create added challenges, as TFWs are unable to access many of the government programs and resources designed for permanent residents. To support the integration of professional skilled migrants who enter as TFWs, it is important that accessible and affordable supports are available.

The re-engineering of Canadian immigration policies has also resulted in a rise in the number of permanent residents entering Canada through the Economic Class, with a consequent decline in the number of immigrants entering through the Family Class (Alboim and Cohl, 2012). This change in policy, while designed to attract skilled immigrants, may in fact make Canada a less desirable destination for some. Only 8.9% of participants in this study were admitted through Family Class, yet the ability to reunite with family living in Canada, as well as to sponsor family members living in the Philippines, was identified, during the qualitative interviews, as a key reason for choosing to migrate to Canada. For a number of participants, the presence of a Family Class set Canada apart from other Western countries, and once IENs arrived in Canada, the presence of well-established family networks was identified as a helpful resource to support integration into the nursing workforce. In Canada immigrants have traditionally been considered future citizens (Alboim and Cohl, 2012). The Family Class provides a mechanism to reunite migrants with family members, and for some

participants this was an influential factor in pursuing Canadian citizenship. Family networks also provide an important form of social capital that can facilitate settlement and adaptation into Canadian society. It is important that policy makers recognize the value of the family immigration class in both the recruitment and settlement of skilled immigrants and that immigration policies do not shift focus entirely to individual skilled workers but rather continue to support the migration of entire families.

Implications for the active recruitment of IENs. In an effort to mitigate the negative consequences of migration, the WHO Global Code of Practice on the International Recruitment of Health Personnel (World Health Organization [WHO], 2010b) provides recommendations for the recruitment process. Article 4.3 of the Code recommends that "Ethical international recruitment practices provide health personnel with the opportunity to assess the benefits and risks associated with employment positions and to make timely and informed decisions" (p. 6). The comments provided by IENs actively recruited to Alberta revealed that a number of participants felt they had received inadequate pre-migration information regarding the RN licensure requirements and employment positions (RN, LPN, or URHW) upon arrival in Canada. Several noted that they were not aware that they had been recruited to a URHW or LPN position rather than a RN position. To ensure IENs have an opportunity to make informed decisions, it is important that detailed and accurate information be provided early in the recruitment process. Information regarding the RN licensure requirements, the documents required, the SEC/CCA, the potential for bridging education, and writing the NCLEX-RN is essential. In addition, as RNs from other countries may be unfamiliar with Canadian nursing practice, clear pre-migration information regarding the roles of RNs, LPNs, and URHWs is required to ensure IENs are fully informed regarding the position they are being recruited to work.

Furthermore, Article 4.4 of the Code states "That migrant health personnel should be hired, promoted and remunerated based on objective criteria, such as levels of qualification, years of experience and degrees of professional responsibility on the basis of equality of treatment with the domestically trained health workforce" (WHO, 2010b, p. 6). Recruiting RNs from the Philippines into URHW positions violates this section of the Code. Unregulated nursing positions do not require the advanced knowledge and skill gained through RN nursing education and recruiting to these positions contributes to deskilling and brain waste of internationally educated health professionals. To uphold the Code, it is important to refrain from the active recruitment of IENs into unregulated nursing positions.

Finally, Article 4.5 of the Code recommends that "Member States should ensure that, subject to applicable laws, including international legal instruments to which they are a party, migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in all terms of employment and conditions of work." (WHO, 2010b, p. 6). Three participants in this research reported exploitive practices by employers in Canada. TFWs were particularly vulnerable, as they feared their work visas would not be renewed without their employer's support. Educating IENs regarding their rights as employees in Canada as well as ensuring employers adhere to all applicable labour laws and codes is important to ensure that IENs are afforded the same working conditions as Canadian health professionals.

Implications for regulatory policies and processes. The primary purpose of regulation is public protection (Benton & Morrison, 2009). As nursing qualifications are not always equivalent between countries (Blythe & Baumann, 2009), it is the role of regulatory boards to protect the public by ensuring nurses meet minimum standards (Bieski, 2007). The migration of IENs from one country to another requires regulators to determine the equivalency of their foreign credentials (Girard & Bauder, 2007) and to put policies and processes in place to assess the competency of the nurse to practice in a new country (Benton & Morrision, 2009). It is important, however, to recognize that changes to regulatory requirements have an impact on other parts of the system. This interconnectedness makes collaboration between regulators, government services, educational institutions, and other stakeholders necessary to ensure the availability and accessibility of resources that are aligned with the needs of IENs. Through collaboration, it may be possible to remove some of the barriers that arise when components of the system act independently.

Furthermore, it is important that regulatory policies and processes are efficient. Procedural delays in the licensure process can create added burden for IENs and extend the time period required to enter the regulated nursing workforce. Further exploration examining the factors that contribute to licensure delays for some IENs is also needed. While delays may stem from inefficient regulatory processes, other factors, for example, a limited number of seats in bridging programs, may also contribute to the length of the licensure process. If delays are to be reduced, it is important that resources and solutions target all associated factors.

Implications for further research. This mixed-methods study described the experiences of a sample of 182 IENs from the Philippines as they integrated into the nursing workforce in the Canadian Prairie Provinces. Following on the findings of this study, a number of areas for

further research have been identified. First, the results of the current study identify a number of challenges, barriers, and stressors that IENs encounter while undergoing the SEC/CCA. Further research to explore strategies to reduce barriers and support IENs as they undergo a SEC/CCA is needed.

Second, the influence of family roles and responsibilities on workforce integration is an important area for future research. The findings of this research revealed that, for some participants, the need to support young children and other family members in both Canada and the Philippines gave rise to a number of challenges. It is important to gain a better understanding of family contexts and how they relate to IEN workforce integration in Canada. To date, only a few studies have examined this phenomenon and further research in this area is warranted.

Third, consistent with the findings reported earlier by Bressler et al. (2017), the results of the current study suggest that, for some IENs, a conflict between their personal values and the values espoused by the host society health system may result in the experience of moral distress. Further research in this area is needed to determine if the experience of moral conflict extends to other groups of IENs and if present, under what circumstances. Furthermore, the concept of culture in relation to moral distress has not been the focus of many research studies and further study of this phenomenon is needed (Bressler et al., 2017).

Fourth, the importance of bridging education emerged as an important theme in this research, yet to date, little evaluative research has been conducted. Currently in Canada bridging programs vary considerably in structure and design. Programs are offered both full-time and part-time and range in length from a few weeks to three years (CASN, 2012; Xu & He, 2013). There is considerable variation in curricula content amongst bridging programs across the country, with differences in the availability of language supports, cultural content, and clinical practice experiences (CASN, 2012; Neiterman & Bourgeault, 2015). Further research is needed to inform the curriculum, design, and development of bridging education to ensure programming is based on evidence and adequately meets the needs of IENs integrating into the nursing workforce.

Fifth, while the importance of proficiency in English language skills for IENs integrating into the Canadian nursing workforce has been well documented in the literature (Blythe et al., 2009; Lum et al., 2015; Newton et al., 2012), few studies have addressed the logistical challenges associated with language programming. Research examining the factors that prevent and facilitate the availability and accessibility of language programs is important to inform policy and decision makers who are responsible for program development and funding. Additionally, the difference in the perceived level of difficulty meeting the English language

requirements reported by RNs as compared to LPNs was a significant finding of this study and has not previously been discussed in Canadian research. Further study to investigate if a correlation exists between meeting required language levels and choosing LPN over RN practice would be beneficial.

Lastly, shifts in immigration policy that favour economic migrants and the subsequent reduction of immigrants eligible to enter through Family Class, as well as the arrival of more IENs as TFWs versus permanent residents, impact the availability and accessibility of both formal and informal supports upon arrival to Canada. Further research is needed to evaluate the impact these and ensuing changes to immigration policies have on the integration of IENs into the nursing workforce in Canada.

Conclusion

The integration of IENs from the Philippines into the nursing workforce in the Canadian Prairie Provinces was a complex process that began with the decision to migrate and entry into Canada. Once in Canada, IENs encountered a number of challenges. To join a regulated nursing profession IENs had to fulfill the requirements of licensure, and once employed, they required the knowledge, skills, and embodied cultural capital necessary for nursing practice in Canada. At times, IENs confronted racism, discrimination, and bullying behaviours toward them. Throughout this process, the capital the IEN held (cultural, social, and financial), along with the availability of host society programs and supports were important resources to facilitate integration. The resources required were situated within a particular context and varied with differing conditions.

While the initial intent of IENs was to work as RNs upon arrival, LPN practice provided a practical option to enter regulated nursing practice in Canada. Participants applied for LPN licensure as a stepping stone to RN practice, which provided an opportunity to build both financial and cultural capital. LPN licensure also offered an alternate career to those IENs who chose not to apply for RN licensure, or who were unable to fulfill the RN licensure requirements. In addition, working as a URHW provided IENs with Canadian health care experience and provided an opportunity to earn needed financial capital as they worked through the licensure process.

However, concluding that LPN and URHW practice is a desired option for IENs must be considered with caution. Delays to complete a SEC/CCA or to enter bridging programs extended the time for some IENs to achieve RN licensure. Working as a URHW, in a "survival job," was required to support themselves and/or their families through this process.

Additionally, the length of time required to complete the RN licensure process led a number of IENs to apply for both RN and LPN licensure simultaneously. The decision to apply for both nursing professions in parallel, while understandable, raises concern. Applying for both processes simultaneously increases the financial cost of licensure for IENs while also placing added demand on host society resources as regulatory body assessments as well as bridging programs would need to be accessed through both RN and LPN processes. Thus, it is important to ensure that regulatory processes are efficient, and IENs can gain RN licensure in a reasonable timeframe. While working as a LPN or URHW can provide a valid option for IENs entering the nursing workforce in Canada, the decision to work in these positions should be based on choice rather than a result of inefficient processes or requirements that are overly bureaucratic.

IENs from the Philippines comprise the highest proportion of IENs working as regulated nurses in Canada, yet many report challenges entering and integrating into the Canadian nursing workforce. To facilitate workforce integration, it is important that host country policies and supports are aligned and programs are accessible and available to IENs. If current migration trends persist, IENs from the Philippines will continue to migrate to the Canadian Prairie Provinces. Investing resources to facilitate their integration is key to support these nurses in becoming valuable members of the nursing workforce in Canada.

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Appendix A: Nursing Regulatory Bodies in the Canadian Prairie Provinces

Manitoba

College of Registered Nurses of Manitoba (CRNM)

College of Licensed Practical Nurses of Manitoba (CLPNM)

Saskatchewan

Saskatchewan Registered Nurses Association (SRNA)

Saskatchewan Association of Licensed Practical Nurses (SALPN)

Alberta

College and Association of Registered Nurses of Alberta (CARNA)

College of Licensed Practical Nurses of Alberta (CLPNA)

Appendix B: Cummins (2009) Letter of Permission

Catherine Baxter

From: Ms Therese Cummins <tcummins@mater.ie>
Sent: Thursday, February 23, 2012 2:23 AM
To: Catherine Baxter
Subject: RE: Article published in Journal of Advanced Nursing
Attachments: Questionnaire - Overseas Perioperative Nurses.doc

Hi Catherine,
Thanks for your email and the very best of luck with your research I will of course attach my questionnaire for you to use or adapt as you need to and I would appreciate the acknowledgment, I have sent to others in the past and I'm always interested in hearing the results, however I have not heard back from anyone, so I would really like to get some feedback from yours as it is very closely linked to my topic,
regards
Therese

From: Catherine Baxter [CBaxter@rrc.mb.ca]
Sent: 21 February 2012 17:31
To: Ms Therese Cummins
Subject: Article published in Journal of Advanced Nursing

Hello Ms. Cummins, my name is Catherine Baxter and I am a lecturer in the nursing degree program at Red River College in Winnipeg, Manitoba, Canada. I am also a PhD student at Queen Margaret University in Edinburgh, Scotland – studying in the area of international nurse migration. Over the weekend I read with great interest your article titled "Migrant nurses' perceptions and attitudes toward integration into perioperative settings". The subject of my PhD research is focused on the integration of Philippine nurses i nto the Canadian Heal h care system.. Many of the issues you identified regarding communication/assertiveness and delegation are also identified challenges for IENs here in Canada. Over the past several months I have been searching for a data collection tool that captures these concepts. In your article you indicated that you had developed your own questionnaire as part of your research. I was wondering if you would be willing to share your data collection tool with me and if it relates would it be possible to adapt it for use in my research study. If any/all of the tool is used full recognition would certainly be given to you as the original developer. Please let me know if you require any additional information. Thank you for considering this request. I look forward to hearing from you. Sincerely, Catherine

Appendix C: Gupta (2009) Letter of Permission

Catherine Baxter

From: Tania Das Gupta <tdasgu@yorku.ca>
Sent: Friday, October 05, 2012 11:37 AM
To: Catherine Baxter
Subject: Re: Request

Hello Catherine,
Thank you for letting me know about your research and I am delighted that you will be looking at racism , a much ignored subject.
I am permitting your use of the questions from my research as long as you acknowledge its source in your thesis.
Best wishes,

Dr. Tania Das Gupta
Department of Equity Studies
Cross-appointed to Department of Sociology

From: Catherine Baxter <CBaxter@RRC.CA>
To: "tdasgu@yorku.ca" <tdasgu@yorku.ca>
Date: 10/05/2012 10:36 AM
Subject: Request

Hello Dr. Das Gupta, I heard you present at the IEN conference a year and a half ago and have subsequently read the book you have published examining racism in nursing. I am currently a PhD student at Queen Margaret University in Scotland and I am in the process of finalizing my questionnaire. The study I will be conducting will explore the integration of Filipino IENs into the Western Canadian Workforce and one of the elements I would like to explore is the presence of racism. With your permission I would like to include the following questions in my questionnaire. (The questions were developed based on the write up you provided in your book). I appreciate your consideration of this request. Please don't hesitate to contact me if you have any questions or require any further clarification. Many thanks Cathy

51. Do you feel that your race/ethnicity/colour has had an effect on your hiring? (getting a job as a nurse)	Yes ☐	No ☐
52. Do you feel that your race/ethnicity/colour has had an effect on where you work?	Yes ☐	No ☐
53. Do you feel that your race/ethnicity/colour has had an effect on your relations with your colleagues?	Yes ☐	No ☐
54. Do you feel that your race/ethnicity/colour has had an effect on your relations with your manager?	Yes ☐	No ☐
55. Do you feel that your race/ethnicity/colour has had an effect on your relations with your patients?		

1

	Yes ☐	No ☐
56. Do you feel that your race/ethnicity/colour has had an effect on your training opportunities?	Yes ☐	No ☐
57. Do you feel that your race/ethnicity/colour has had an effect on your performance reviews?	Yes ☐	No ☐
58. Do you feel that your race/ethnicity/colour has had an effect on your ability to be promoted to a higher nursing position?	Yes ☐	No ☐

Appendix D: Online Questionnaire

Q1 Philippine Nursing Survey
Q2 Philippine Nurse Migration in Canada - LPN / RN survey
Q3 Are you a Licensed Practical Nurse (LPN) or a Registered Nurse (RN)?

- LPN (1)
- RN (2)
- None of the above (3)

If None of the above Is Selected, Then Skip To End of Survey

Q4 Did you complete your entry level nursing education in the Philippines?

- Yes (1)
- No (2)

If No Is Selected, Then Skip To End of Survey

Q5 Were you previously registered as a Registered Nurse in the Philippines?

- Yes (1)
- No (2)

If No Is Selected, Then Skip To End of Survey

Q6 What province are you currently Licensed as an {LPN/RN/ChoiceGroup/SelectedChoices}?

- British Columbia (1)
- Alberta (2)
- Manitoba (3)
- Saskatchewan (4)

Q7 SECTION ONE: Education and Nursing Experience

Q8 In what year did you first qualify as a nurse in the Philippines? (cue: what year did you pass your licensure exam?)

Year (1) _____

Q9 What University/College degree(s) did you obtain the Philippines? Check all that apply

- Baccalaureate Degree in Nursing (1)
- Baccalaureate Degree in another discipline (2)
- Master's Degree (3)
- PhD (4)
- Other (please specify) (5) _____

Q10 After you qualified as a nurse in the Philippines, and before you came to Canada, what type of work did you do? In the chart below please check all the boxes that apply.

	I worked in this position for 0 - 6 months (1)	I worked in this position for 6 months – 1 year (2)	I worked in this position for 1 – 5 years (3)	I worked in this position for more than 5 years (4)	I did not work in this position (5)
Non nursing position in the Philippines (1)	❍	❍	❍	❍	❍
Volunteer nurse in the Philippines (2)	❍	❍	❍	❍	❍
Paid nursing position in the Philippines (3)	❍	❍	❍	❍	❍
Paid nursing position in another country before moving to Canada (4)	❍	❍	❍	❍	❍
Non nursing position in another country before moving to Canada (5)	❍	❍	❍	❍	❍
Other (Please specify in comments space provided) (6)	❍	❍	❍	❍	❍

Q11 Which of the following best describes the practice setting you worked most often as a RN before moving to Canada? Please check only one answer

- Acute Care hospital (1)
- Long term care facility (2)
- Public health/School health/Community health (3)
- Other (Please Specify) (4) _____
- Did not work as a Registered Nurse before coming to Canada (5)

Q12 Which of the following best describes your job title for your main job as a RN before moving to Canada? Please check only one answer.

- Staff Nurse (1)
- Nurse Educator (2)
- Nurse Manager (3)
- Other (please specify) (4) _____

Q13 SECTION TWO: Becoming a Nurse in Canada

Answer If Are you a Licensed Practical Nurse (LPN) or a Registered Nurse (RN)... LPN Is Selected

Q74 When did you first become a Licensed Practical Nurse (LPN) in Canada? (ie. Join the register as a LPN)

Year (1) _____

Answer If Are you a Licensed Practical Nurse (LPN) or a Registered Nurse (RN) ... RN Is Selected

Q14 What year did you first apply for registration as an RN in Canada?

Year (1) _____

Answer If Are you a Licensed Practical Nurse (LPN) or a Registered Nurse (RN)... RN Is Selected

Q15 What year did you first become a Registered Nurse (RN) in Canada? (ie. Join the register as a RN)

Year (1) _____

Answer If Are you a Licensed Practical Nurse (LPN) or a Registered Nurse (RN)... RN Is Selected

Q16 In what province or territory did you first the Register as an RN in Canada?

- British Columbia (1)
- Alberta (2)
- Saskatchewan (3)
- Manitoba (4)
- Ontario (5)
- Quebec (6)
- Labrador and Newfoundland (7)
- New Brunswick (8)
- Prince Edward Island (9)
- Nova Scotia (10)
- Yukon (11)
- Northwest Territories (12)
- Nunavut (13)
- Other (please specify) (14) _____

Answer If Are you a Licensed Practical Nurse (LPN) or a Registered Nurse (RN) RN Is Selected

Q17 Please rate how difficult each stage of the licensing process was.

	Impossible or very difficult (1)	Difficult (2)	Neither easy or difficult (3)	Easy (4)	Very Easy or no problem (5)	Not applicable (6)
Obtaining original transcripts or documents (1)	❍	❍	❍	❍	❍	❍
Meeting the English Requirements (2)	❍	❍	❍	❍	❍	❍
Completing the Competence Assessment (SEC/CCA) (3)	❍	❍	❍	❍	❍	❍
Enrolling in the required educational upgrading (bridge program) (4)	❍	❍	❍	❍	❍	❍
Doing well academically in the required educational upgrading (bridge program) (5)	❍	❍	❍	❍	❍	❍
Passing the CRNE (6)	❍	❍	❍	❍	❍	❍
Having to resubmit documents that expire during registration (e.g. language tests) (7)	❍	❍	❍	❍	❍	❍

Answer If Are you a LPN or RN… LPN Is Selected

Q75 Please rate how difficult each stage of the licensing process was.

	Impossible or very difficult (1)	Difficult (2)	Neither easy or difficult (3)	Easy (4)	Very Easy or no problem (5)	Not applicable (6)
Obtaining original transcripts or documents (1)	❍	❍	❍	❍	❍	❍
Meeting the English Requirements (2)	❍	❍	❍	❍	❍	❍
Completing the Competence Assessment (3)	❍	❍	❍	❍	❍	❍
Enrolling in the required educational upgrading (bridge program) (4)	❍	❍	❍	❍	❍	❍
Doing well academically in the required educational upgrading (bridge program) (5)	❍	❍	❍	❍	❍	❍
Passing the CPNRE (6)	❍	❍	❍	❍	❍	❍
Having to resubmit documents that expire during registration (e.g. language tests) (7)	❍	❍	❍	❍	❍	❍

Answer If Are you a LPN or RN… RN Is Selected

Q18 How helpful were each of the following sources in providing you with information and support about becoming a Registered Nurse in Canada (i.e. the Registration Process)? If no support was provided, please choose ‘none provided’.

	Very helpful (1)	Quite helpful (2)	Neutral (3)	Not very helpful (4)	Not at all helpful (5)	None provided (6)
The Nursing Regulator (ie. CRNBC; CARNA; SRNA; CRNM) (1)	❍	❍	❍	❍	❍	❍
The Nursing Union (2)	❍	❍	❍	❍	❍	❍
Immigration/government counsellors (3)	❍	❍	❍	❍	❍	❍
Employer/Regional Health Authority (4)	❍	❍	❍	❍	❍	❍
Nursing recruitment Officer (5)	❍	❍	❍	❍	❍	❍
Family (6)	❍	❍	❍	❍	❍	❍
Friends (7)	❍	❍	❍	❍	❍	❍
Other IENs (8)	❍	❍	❍	❍	❍	❍
Members of the Philippine community (9)	❍	❍	❍	❍	❍	❍
Philippine Nursing Association (10)	❍	❍	❍	❍	❍	❍
Preceptor/Mentor (11)	❍	❍	❍	❍	❍	❍
Other (Please Specify in comments space provided) (12)	❍	❍	❍	❍	❍	❍

Answer If Are you a LPN or RN ... LPN Is Selected

Q76 How helpful were each of the following sources in providing you with information and support about becoming a Licensed Practical Nurse in Canada? If no support was provided, please choose ‘none provided’.

	Very helpful (1)	Quite helpful (2)	Neutral (3)	Not very helpful (4)	Not at all helpful (5)	None provided (6)
The Nursing Regulator (ie. CLPNBC; CLPNA; SALPN; CLPNM) (1)	❍	❍	❍	❍	❍	❍
The Nursing Union (2)	❍	❍	❍	❍	❍	❍
Immigration/government counsellors (3)	❍	❍	❍	❍	❍	❍
Employer/Regional Health Authority (4)	❍	❍	❍	❍	❍	❍
Nursing recruitment Officer (5)	❍	❍	❍	❍	❍	❍
Family (6)	❍	❍	❍	❍	❍	❍
Friends (7)	❍	❍	❍	❍	❍	❍
Other IENs (8)	❍	❍	❍	❍	❍	❍
Members of the Philippine community (9)	❍	❍	❍	❍	❍	❍
Philippine Nursing Association (10)	❍	❍	❍	❍	❍	❍
Preceptor/Mentor (11)	❍	❍	❍	❍	❍	❍
Other (Please Specify in comments space provided) (12)	❍	❍	❍	❍	❍	❍

Q19 Did you attend a Nursing Bridging Program/Upgrading program in Canada?

- Yes (1)
- No (2)

Answer If Did you attend a Nursing Bridging Program/Upgrading program... Yes Is Selected

Q20 How helpful was the bridging program/upgrading program in helping you become a ${q://QID3/ChoiceGroup/SelectedChoices} in Canada?

- Very helpful (1)
- Somewhat helpful (2)
- Not very helpful (3)
- Not at all helpful (4)
- Don't know (5)

Q21 How difficult it was to meet the financial requirements listed below.

	Impossible or Very Difficult (1)	Difficult (2)	Neither easy or difficult (3)	Easy (4)	Very Easy or No Problem (5)
Paying all the costs associated with the Registration process in Canada (application fees, exam fees, tuition fees etc.) (1)	❍	❍	❍	❍	❍
Paying for essentials (food, clothing, housing, transportation etc.) for yourself/family throughout the Registration process (2)	❍	❍	❍	❍	❍

Q22 Please indicate the primary source of financial support you had while moving through the licensing process.

- Employment Insurance (EI) (1)
- Government loan (2)
- Bank loan (3)
- Personal Savings (4)
- Bursary/Scholarship (5)
- Spouse (6)
- Parents (7)
- Other Family members (8)
- Part time work (9)
- Full Time work (10)
- Other (please Specify) (11)

Answer If Are you a LPN or RN ... RN Is Selected

Q23 Before you received your Registration as a Nurse did you apply / work as a Licensed Practical Nurse (LPN) in Canada?

- Yes (1)
- No (2)

Answer If Are you a LPN or RN ... LPN Is Selected Or Before you received your Registration as a Nurse did you ... Yes Is Selected

Q24 Please use the space provided to discuss what factors led to your decision to apply/work as an LPN in Canada?

Answer If Are you a Licensed Practical Nurse (LPN) or a Registered ... LPN Is Selected

Q25 Since arriving in Canada have you also applied for Registration as a Registered Nurse (RN)?

- Yes (1)
- No (2)

If No Is Selected, Then Skip To Please use this space to describe what factors influenced your decision not to apply for or continue to

Answer If Are you a Licensed Practical Nurse (LPN) or a Registered ... LPN Is Selected

Q26 What stage of the registration process are you currently at? Please choose only one answer.

- Credential/Document assessment (1)
- English Language assessment/training (2)
- Completing the Competence/SEC assessment (3)
- Educational Upgrading (Bridging) (4)
- Writing the Canadian Registered Nurse Exam (CRNE) (5)
- No longer seeking Registration as a Registered Nurse (6)

Answer If Are you a Licensed Practical Nurse (LPN) or a Registered ... LPN Is Selected

Q27 In the boxes below please rank how difficult each stage of the registration process is/was. If you have not reached the stage yet, please tick 'not applicable'.

	Impossible or Very Difficult (1)	Difficult (2)	Neither easy or difficult (3)	Easy (4)	Very Easy or no problem (5)	Not applicable (6)
Obtaining original transcripts or documents (1)	❍	❍	❍	❍	❍	❍
Meeting the English Requirements (2)	❍	❍	❍	❍	❍	❍
Completing the Competence/SEC Assessment (3)	❍	❍	❍	❍	❍	❍
Enrolling in the required educational upgrading (bridge program) (4)	❍	❍	❍	❍	❍	❍
Doing well academically in the required educational upgrading (bridge program) (5)	❍	❍	❍	❍	❍	❍
Passing the CRNE (6)	❍	❍	❍	❍	❍	❍

Answer If Are you a Licensed Practical Nurse (LPN) or a Registered ... LPN Is Selected

Q28 How much longer do you expect it will take you to complete the registration process to become an RN?

- 0-6 months (1)
- 6-12 months (2)
- Greater than 12 months (3)

Answer If Since arriving in Canada have you also applied for Regist... No Is Selected

Q29 Please use this space to describe what factors influenced your decision not to apply for or continue to seek Registration as a Registered Nurse.

Q30 SECTION THREE: Working as a Nurse in Canada

Q31 Before you received you became a ${q://QID3/ChoiceGroup/SelectedChoices} did you work as an unregulated health worker (ie. Health care aide; home support worker; nurse's aide etc.) in Canada?

- Yes (1)
- No (2)

Answer If Before you received you became a ${q://QID3/ChoiceGr... Yes Is Selected

Q32 What factors led to your decision to apply/work as an unregulated health worker in Canada?

Q33 Are you currently working as ...?

- A Registered Nurse (RN) (1)
- A Licensed Practical Nurse (LPN) (2)
- Both a Registered Nurse (RN) and a Licensed Practical Nurse (LPN) (3)
- None of the Above (4)

Answer If Are you currently working as ...? None of the Above Is Selected

Q80 What factors led to your decision to not work as an RN and/or LPN at this time?

Q35 From the time you first became a ${q://QID3/ChoiceGroup/SelectedChoices} how long did it take you to find your first job as a ${q://QID3/ChoiceGroup/SelectedChoices} in Canada?

- Less than 6 months (1)
- 6 months to 1 year (2)
- More than 1 year (3)

Q36 How did you find out about your first nursing position as a ${q://QID3/ChoiceGroup/SelectedChoices}? Check all that apply

- Job posting on the internet or newspaper (1)
- Worked in another position at the hospital/facility (ie. As a HCA/LPN/volunteer) (2)
- Completed a clinical practicum on the unit or in the hospital/facility that you obtained your first nursing position (3)
- Family (4)
- Friends (5)
- Preceptor/Mentor (6)
- Other IENs (7)
- Other Nurses (8)
- Members of the Philippine community (9)
- Members of the Philippine nursing community (10)
- Other (please specify) (11) _____

Q37 Is your current employer your first employer as a ${q://QID3/ChoiceGroup/SelectedChoices} in Canada?

- Yes (1)
- No (2)

Answer If Is your current employer your first employer as a ${q://Q... No Is Selected

Q38 How many other employers in Canada have you worked for as a ${q://QID3/ChoiceGroup/SelectedChoices} (not including your current employer)?

Number of employers (1) _____

Q39 Which of the following best describes your current employment situation for your main job?

- Employed and working full-time (1)
- Employed and working part -time (2)
- Employed and working casual (3)
- Employed and currently on a leave of absence (4)
- Self-employed (5)

Q40 How many different employers do you currently work for?

- None (1)
- One employer (2)
- Two employers (3)
- More than two employers (4)

Q41 Would you like to work:

- Fewer hours (1)
- About the same number of hours (2)
- More hours (3)

Q42 Which of the following most closely describes your job title for your main job in Canada? Please tick only one answer.

- Staff Nurse (1)
- Charge Nurse / Clinical Resource Nurse (2)
- Unit Manager (3)
- Educator (4)
- Community Health Nurse (5)
- Other (please specify) (6) _____

Q43 Which of the following best describes the practice setting you work most of your time?

- Acute Care Unit (1)
- Rehabilitation Unit (2)
- Chronic Care Unit (3)
- Personal Care Home/ Home health care (4)
- Community Health (5)
- Other (Please specify) (6) _____

Q44 How long have you worked in your current position?

Year(s) (1)
Month(s) (2)

Q45 How long do you plan to stay in your current position?

Year(s) (1)
Month(s) (2)

Q46 Do you think your current nursing position is appropriate given your knowledge and experience? (i.e. Do you feel your qualifications are a good fit; or do you feel over/underqualified?)

- Yes (1)
- No (2)

Q47 Please explain: _____

Q48 Integration into the nursing workforce

Q49 The following questions examine some of the challenges you may have experienced integrating into your current work setting. In the following section, please indicate the extent to which you agree or disagree with the following statements

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)	Don't know (6)
I find it difficult to communicate in English in the work setting (1)	❍	❍	❍	❍	❍	❍
The different accents are difficult to understand in the work setting (2)	❍	❍	❍	❍	❍	❍
Therapeutic communication with patients is difficult (3)	❍	❍	❍	❍	❍	❍
Therapeutic communication with family members is difficult (4)	❍	❍	❍	❍	❍	❍
Communicating in an assertive manner with other nursing staff is difficult (5)	❍	❍	❍	❍	❍	❍
Communicating in an assertive manner with doctors is difficult (6)	❍	❍	❍	❍	❍	❍

Communicating in an assertive manner with members of the inter-disciplinary team is difficult (7)	❍	❍	❍	❍	❍	❍
Communicating in an assertive manner with the support staff (i.e. health care aides / unit clerks) is difficult (8)	❍	❍	❍	❍	❍	❍
Delegating tasks to my nursing colleagues is easy (9)	❍	❍	❍	❍	❍	❍
Delegating tasks to the support staff is easy (ie. bathing patients/making beds) (10)	❍	❍	❍	❍	❍	❍
Nursing practices in Canada are the same as in the Philippines (11)	❍	❍	❍	❍	❍	❍
The roles and responsibilities of nurses in Canada (ie. Scope of practice) are the same as in the Philippines (12)	❍	❍	❍	❍	❍	❍

Adequate time is given to achieve competence in new nursing skills (13)	❍	❍	❍	❍	❍	❍
Work colleagues understand my cultural needs (14)	❍	❍	❍	❍	❍	❍
Work colleagues consider my cultural needs (15)	❍	❍	❍	❍	❍	❍

Q50 How helpful were each of the following supports in helping you adjust/adapt to your first nursing job in Canada? If no support was provided, please choose not applicable.

	Very helpful (1)	Quite helpful (2)	None of these (3)	Not very helpful (4)	Not at all helpful (5)	Not applicable (6)
Attending Hospital/unit Orientation (1)	❍	❍	❍	❍	❍	❍
Working with a preceptor/buddy nurse (2)	❍	❍	❍	❍	❍	❍
Attending a Bridging Program (3)	❍	❍	❍	❍	❍	❍
Support from other nursing staff on the unit (4)	❍	❍	❍	❍	❍	❍
Support from other Internationally Educated Nurses (5)	❍	❍	❍	❍	❍	❍
Support from a Nursing Educator (6)	❍	❍	❍	❍	❍	❍
Support from your manager or direct supervisor (7)	❍	❍	❍	❍	❍	❍

Q51 Were there any other supports that would have helped you adapt/adjust to your first nursing job?

Q52 The following questions examine if you feel you have received treatment equal to that given to Canadian educated nurses. Please indicate the extent to which you agree or disagree with the following statements. My race/ethnicity/colour has had an effect on...

	Strongly Disagree (1)	Disagree (2)	Neither Agree nor Disagree (3)	Agree (4)	Strongly Agree (5)
my hiring / getting a job as a nurse (1)	❍	❍	❍	❍	❍
where I work. (2)	❍	❍	❍	❍	❍
my relations with my colleagues (3)	❍	❍	❍	❍	❍
my relations with my manager. (4)	❍	❍	❍	❍	❍
my relations with my patients. (5)	❍	❍	❍	❍	❍
my training opportunities. (6)	❍	❍	❍	❍	❍
my performance reviews. (7)	❍	❍	❍	❍	❍
my ability to be promoted to a higher nursing position. (8)	❍	❍	❍	❍	❍

Q53 Please use this space to state any other comments on your experience as an Internationally Educated Nurse in Canada or any other information which you feel is relevant.

Q54 Background

Q55 Which of the following factors most influenced your decision to move to Canada?

- Financial Reasons (better wages; to be able to send money back to the Philippines) (1)
- Social Reasons (to join family and friends; to enable your children to grow up in Canada) (2)
- Professional Reasons (to gain professional development; to work as a nurse) (3)
- Personal Reasons (to travel; experience a different way of living) (4)
- Other (please specify) (5) _____

Q56 What was your immigration category on arrival to Canada?

- Economic Class (Skilled Worker / Provincial Nominee) (1)
- Family Class (2)
- Live in Caregiver (3)
- Temporary work visa (4)
- Temporary student visa (5)
- Other (please specify) (6) _____

Q57 Who was the primary applicant?

- You (1)
- Your spouse (2)
- Your parents (3)
- Other (please specify) (4)

Q58 In what year did you come to Canada?

- 2008 (1)
- 2009 (2)
- 2010 (3)
- 2011 (4)
- 2012 (5)
- Other (please specify) (6) _____

Q59 How old are you?

- 20 - 30 (1)
- 31-40 (2)
- 41 - 49 (3)
- 50 or older (4)

Q60 What is your sex?

- Male (1)
- Female (2)

Q61 Are you married or with a partner?

- Yes (1)
- No (2)

Answer If Are you married or with a partner? Yes Is Selected

Q62 Is your husband/wife/partner currently:

- Living with you in Canada (1)
- Living in the Philippines (2)
- Other (please specify) (3) _____

Q63 Do you have children?

- Yes (1)
- No (2)

Answer If Do you have children? Yes Is Selected

Q64 How many in each age group?

- Pre-school (1)
- School Age (2)
- Older (3)

Answer If Do you have children? Yes Is Selected

Q65 Are your children currently:

- Living with you in Canada (1)
- Living in the Philippines (2)
- Other (please specify) (3) _____

Q66 What is your current immigration status in Canada?

- Temporary work permit (1)
- Landed Immigrant / Permanent Resident (2)
- Canadian Citizen (3)
- Other (please specify) (4) _____

Q67 Which province do you currently live in?

- Manitoba (1)
- Saskatchewan (2)
- Alberta (3)
- British Columbia (4)

Q68 Further Research

As part of my ongoing research into the experiences of IENs from the Philippines, I may wish to contact you again to invite you to participate in a focus group interview.

Q69 Would you be interested in being contacted in the future?

- Yes (1)
- No (2)

If No Is Selected, Then Skip To End of Survey

Q70 To ensure the researcher has no ability to match your name with your responses on this survey, the contact information you provide below will be submitted to the researcher separate from your survey answers.

Name (1)
Phone Number (2)
Email (3)

Q71 Thank you for completing this questionnaire!

Appendix E: Interview Guides

LPN Interview Guide

1) I would like to begin by asking you about your reasons for choosing to move to Canada. Can you tell me a little about your reasons for moving to Canada? Was Canada your first choice of countries? If not, why not? If yes, what made it your first choice? Did you come to Canada directly from the Philippines or were you in another country in between? If yes, which country and did you work in? and did you work in a nursing or non nursing role in that country? Can you also tell my some of your reasons for choosing to live in [town, city, province]?

2) I would next like to explore some of the experiences you have had working as a nurse in Canada. Can you begin by telling me a little about your current position [prompts: setting, rural/urban, position].
   a) What did/do you find as the most challenging part of working as a nurse in Canada? ? [assertiveness, communication, delegation, scope of practice, skills etc.]
   b) What is/was the easiest part of adjusting to work as a nurse in Canada?
   c) How different is your nursing practice now compared with your nursing practice in the Philippines?
   d) Do you feel your nursing education in the Philippines adequately prepared you to work in Canada?
   e) What supports/resources did you find most helpful in assisting you to adjust to nursing in Canada? [orientation, preceptor, manager, educator, colleague] - how did this program/person assist you to adjust – did you get enough support – what other supports might have been helpful?
   f) What factors led to your decision to work as a LPN in Canada?
   g) Do you think your current nursing position is appropriate given your knowledge and experiences?

3) The next question is about the process of becoming licensed as an LPN in Canada. Can you tell about your experiences with the licensing process: Any challenges you encountered? What supports you found helpful?

4) Since arriving in Canada have you also applied for registration as a RN?
   a) If yes: What stage of the registration process are you currently at? What have been the major barriers or challenges you've experienced with the Registration process? What did you find most helpful?
   b) If No or yes [but no longer seeking registration ask]: What factors influenced your decision not to continue with the Registration process? [prompt: a number of survey respondents indicated that the bridging education requirement was very difficult – did you find this? If so, can you tell me more about this?]

5) The next few questions focus on the reaction of your colleagues/managers and patients toward you at work.
    a) A number of respondents on the survey indicated that their colleagues had been quite supportive and welcoming. Was this your experience? If yes, in what way. If not, can you tell me more about this [may lead into next question].

    b) In the survey a number of the respondents indicated that they had experienced some form of racism or bullying in the workplace. Have you experienced racism? Have you experienced bullying? Can you tell me a little about this? When you experienced this how did you respond? [did you receive any support from your manager, educator, colleague]? Do you know if the facility where you work has any policies regarding racism, discrimination or bullying?

6) That is all the questions that I have but is there anything else you would like to add?

Thank you for sharing your experiences with me.

RN Interview Guide

1) I would like to begin by asking you about your reasons for choosing to move to Canada. Can you tell me a little about your reasons for moving to Canada? Was Canada your first choice of countries? If not, why not? If yes, what made it your first choice? Did you come to Canada directly from the Philippines or were you in another country in between? If yes, which country and did you work in? and did you work in a nursing or non nursing role in that country? Can you also tell my some of your reasons for choosing to live in [town, city, province] [rural or urban]?
2) I would next like to explore some of the experiences you have had working as a nurse in Canada. Can you begin by telling me a little about your current position [prompts: setting, rural/urban, position].
    a. What did/do you find as the most challenging part of working as a nurse in Canada? [assertiveness, communication, delegation, scope of practice, skills etc.]
    b. What is/was the easiest part of adjusting to work as a nurse in Canada?
    c. How different is your nursing practice now compared with your nursing practice in the Philippines?
    d. Do you feel your nursing education in the Philippines adequately prepared you to work in Canada?
    e. What supports/resources did you find most helpful in assisting you to adjust to nursing in Canada? [orientation, preceptor, manager, educator, colleague] - how did this program/person assist you to adjust – did you get enough support – what other supports might have been helpful?
    f. What factors led to your decision to work as a RN in Canada?
    g. Do you think your current nursing position is appropriate given your knowledge and experiences?
3) The next question is about the process of becoming registered as a RN in Canada. Can you tell about your experiences with the licensing process: Any challenges you encountered? What supports you found helpful?
4) The next few questions focus on the reaction of your colleagues/managers and patients toward you at work.
    a. A number of respondents on the survey indicated that their colleagues had been quite supportive and welcoming. Was this your experience? If yes, in what way. If not, can you tell me more about this [may lead into next question].
    b. In the survey a number of the respondents indicated that they had experienced some form of racism or bullying in the workplace. Have you experienced racism? Have you experienced bullying? Can you tell me a little about this? When you experienced this how did you respond? [did you receive any support from your manager, educator, colleague]? Do you know if the facility where you work has any policies regarding racism, discrimination or bullying?
5) That is all the questions that I have but is there anything else you would like to add?

URHW Interview Guide

Screening Questions

Are an internationally educated nurse from the Philippines who arived in Canada after January 2008

Yes ❒ **No** ❒ Skip to end

Did you take your entry level nursing education in the Philippines?

Yes ❒ **No** ❒ Skip to end

Were you previously registered as a Registered Nurse in the Philippines?

Yes ❒ **No** ❒ Skip to end

Are you currently working as a (HCA/home support worker etc.)?

Yes ❒ **No** ❒ Skip to end

What province are you currently living in?

Alberta ❒
Saskatchewan ❒
Manitoba ❒

Section A: Education and Nursing Experience

1. In what year did you first qualify as a nurse in the Philippines?
   (cue: what year did you pass your licensure exam?)

2. What University/College did you attend in the Philippines for your nursing education?

3. What University/College degree(s) **in nursing** did you obtain in the Philippines? *Check all that apply*

   Baccalaureate Degree in Nursing ❒
   Master's Degree ❒
   Other (Please specify)

4. Did you study any other profession/discipline at University/College prior to studying nursing?

   Yes (Please specify)
   No ❒

The following questions examine your work history **prior** to moving to Canada.

Before coming to Canada and after you qualified as a nurse in the Philippines did you:…….
How long?

	worked in this position for 0 – 6 months	worked in this position for 6 months – 1 year	worked in this position for 1 – 5 years	worked in this position for more than 5 years	did not work in this position
5. work in a **non nursing** position in the Philippines	❒	❒	❒	❒	❒
6. work as a **volunteer nurse** in the Philippines	❒	❒	❒	❒	❒
7. work in a **paid nursing** position in the Philippines	❒	❒	❒	❒	❒
8. work in a **non nursing** position in another country *before moving to Canada*	❒	❒	❒	❒	❒
9. work in a **paid nursing** position in another country *before moving to Canada*	❒	❒	❒	❒	❒
10. Other: Please specify	❒	❒	❒	❒	❒

11. Which of the following best describes the practice setting you worked **most often** as a Registered Nurse before moving to Canada? *Check only one answer*

a. Acute Care hospital ❒
b. Long term care facility ❒
c. Public health/ Community health ❒
d. School Health/Occupational Health ❒
e. Other (Please Specify)

f. Did not work as a Registered Nurse before coming to Canada ❒

12. Which of the following best describes your job title for your **main job** as a Registered nurse before moving to Canada? C*heck only one answer*

a. Staff Nurse ❒
b. Nurse Educator ❒
c. Nurse Manager ❒
d. Other (please specify)

e. Did not work as a Registered Nurse before coming to Canada ❒

Section B: Challenges and supports encountered in becoming a Professional Nurse in Canada

13. When you first arrived in Canada did you plan to work as a Registered Nurse?

Yes ❒
No ❒ Please explain:

14. Since arriving in Canada have you applied for Registration as a Registered Nurse (RN)?

Yes ❒ **If yes, a) when did you apply?**

b) *Who provided you with information and support about the process of applying/ becoming registered as a nurse in Canada?* (***Prompts: For example the regulatory, the union, nurse recruiters, government officials, friends, family, other members of the Philippine community etc.***

No ❒ **If no, skip to question 17**

15. What stage of the registration process are you currently at? *Please choose only one answer*.

Credential/Document assessment	❒
English Language assessment/training	❒
Completing the Competence/SEC assessment	❒
Educational Upgrading (Bridging)	❒
Writing the Canadian Registered Nurse Exam (CRNE)	❒
No longer seeking Registration as a Registered Nurse	❒ **Go to question 18**

16. How much longer do you expect it will take you to complete the registration process to become an RN?

Less than 6 months	❒ Ask question 19
6-12 months	❒ Ask question 19
Greater than 12 months	❒ Ask question 19

17. What factors influenced your decision not to apply for Registration as a Registered Nurse? *(Prompts: for example was you decision impacted by personal, family or financial reasons; problems with credential recognition; understanding the licensing process in Canada?* **Skip to Question 21**

18. What factors influenced your decision not to continue with the Registration Process? *(Prompts: for example was you decision impacted by personal, family or financial reasons; problems with credential recognition; understanding the licensing process in Canada?*

19. What have been/were the major barriers/challenges that you have experienced in applying to become an RN in Canada? *(Prompts: What difficulties or problems have you experienced? for example have you experienced any personal, family or financial challenges; problems with credential recognition; understanding the licensing process in Canada; knowing who to contact for help etc?)*

20. What would have made the process easier? *(for example, what supports would have been helpful? ie, financial loans or bursaries; information on the registration process etc) Prompts: Can you tell me more about….. Can you explain what you mean by….)*

21. Since arriving in Canada have you applied for Registration as a Licensed Practical Nurse (LPN)?

Yes ❒ **a)** when did you apply?

b) Who provided you with information and support about the process of applying/ becoming licensed as a nurse in Canada (***Prompts: For example the regulatory, the union, nurse recruiters, government officials, friends, family, other members of the Philippine community etc.***

No ❒ **If no, skip to question 25**

22. What factors led to your decision to apply for an LPN licence in Canada?

23. What stage of the licensing process are you currently at? *Please choose only one answer*.

Credential/Document assessment	❒
English Language assessment/training	❒
Completing the Competence assessment	❒
Educational Upgrading (Bridging)	❒
Writing the Canadian Practical Nurses Registration Exam (CPNRE)	❒
No longer seeking Registration as a Registered Nurse	❒ **Go to question 26**

24. How much longer do you expect it will take you to complete the registration process to become an LPN?

Less than 6 months	❒ **Ask question 27**
6-12 months	❒ **Ask question 27**
Greater than 12months	❒ **Ask question 27**

25. What factors influenced your decision not to apply for Registration as a Licensed Practical Nurse? *(Prompts: for example was you decision impacted by personal, family or financial reasons; problems with credential recognition; understanding the licensing process in Canada?* **Skip to Question 29**

26. What factors influenced your decision not to continue with the Registration Process to become an LPN? *(Prompts: for example was you decision impacted by personal, family or financial reasons; problems with credential recognition; understanding the licensing process in Canada?*

27. What have been/were the major barriers/challenges that you have experienced in applying to become an LPN in Canada? *(Prompts: What difficulties or problems have you experienced? for example have you experienced any personal, family or financial challenges; problems with credential recognition; understanding the licensing process in Canada; knowing who to contact for help etc.?*

28. What would have made the process easier? *(for example, what supports would have been helpful? ie, financial loans or bursaries; information on the registration process etc.) Prompts: Can you tell me more about….. Can you explain what you mean by….)*

29. What factors led you to work in your current position as an unregulated health care worker? *(Prompts: for example was you decision impacted by personal, family or financial reasons; problems with credential recognition; understanding the licensing process in Canada?*

Section C: Workforce Information

30. Are you currently working: Fulltime _____ Part time _____ Casual _____

31. How many different employers do you currently have? _____

32. Would you like to work: Fewer hours _____

About the same number of hours _____

More hours _____

33. The following questions examine if you feel you have received equal treatment to Canadian educated nurses. In the following section, please indicate the extent to which you agree or disagree with the following statements (Please indicate with the most appropriate number).

Strongly Disagree =1 Disagree = 2 Neither agree or disagree = 3 Agree = 4 Strongly Agree = 5 Don't Know

	Strongly Disagree	**Disagree**	**Neither agree or disagree**	**Agree**	**Strongly Agree**	**Don't Know**
a. I feel that my race/ethnicity/colour has had an effect on my hiring. (getting your current job as an unregulated health worker)	1	2	3	4	5	6
b. I feel that my race/ethnicity/colour has had an effect on where I work.	1	2	3	4	5	6
c. I feel that my race/ethnicity/colour has had an effect on my relations with my colleagues.	1	2	3	4	5	6
d. I feel that my race/ethnicity/colour has had an effect on my relations with my manager.	1	2	3	4	5	6
e. I feel that my race/ethnicity/colour has had an effect on my relations with my patients.	1	2	3	4	5	6
f. I feel that my race/ethnicity/colour has had an effect on my training opportunities.	1	2	3	4	5	6
g. I feel that my race/ethnicity/colour has had an effect on my performance reviews.	1	2	3	4	5	6

33. b) If you answered Agree or Strongly agree for any questions please explain your answer

Section D: Background

34. Which of the following factors influenced your decision to move to **Canada**?
(Check all that apply)

a. Financial Reasons (better wages; to be able to send money back to the Philippines) ❒
b. Social Reasons (to join family and friends; to enable your children to grow up in Canada) ❒
c. Professional Reasons (to gain professional development; to work as a nurse) ❒
d. Personal Reasons (to travel; experience a different way of living) ❒
e. Other (Please Specify) ❒

35. If you checked more than one box in question 30, what was your **Primary** reason for moving to Canada? ***Check only one box***

a. Financial Reasons (better wages; to be able to send money back to the Philippines) ❒
b. Social Reasons (to join family and friends; to enable your children to grow up in Canada) ❒
c. Professional Reasons (to gain professional development; to work as a nurse) ❒
d. Personal Reasons (to travel; experience a different way of living) ❒
e. Other (As stated in question 30) ❒

36. What was your immigration category on arrival to Canada?

a. Skilled Worker/Provincial Nominee ❒
b. Family Class ❒
c. Live in Caregiver ❒
d. Temporary work visa ❒
e. Temporary student visa ❒
f. Visitor's visa ❒
g. Other (Please Specify) ❒

37. Who was the primary applicant?

a. You ❒
b. Your spouse ❒
c. Your parents ❒
d. Other (Please specify) ❒

38. In what year/month did you come to Canada?

a. 2008 ❒ month:
b. 2009 ❒ month:
c. 2010 ❒ month:
d. 2011 ❒ month:
e. 2012 ❒ month:
f. Other (Please specify) ❒ month:

39. How old are you?

a. Under 20 ❒
b. 20 - 30 ❒
c. 31-40 ❒
d. 41 - 49 ❒
e. 50 or older ❒

40. What is your sex? Male ❒ Female ❒

41. Are you Married or with a partner?

Yes ❒ **If Yes, Please answer question 42 and continue**
No ❒ **If No, Please answer question 43 and continue**

42. Is your husband/wife/partner currently: *Please tick the correct answer*

a. Living with you in Canada ❒
b. Living in the Philippines ❒
c. Other (Please specify) ❒

43. Do you have children? *Please tick the correct answer*

Yes ❒ **If Yes, skip to question 44 and continue**
No ❒ **If No, skip to question 46 and continue**

44. How many in each age group? *Please write the number in each category; write 0 for none*

Pre-school	
School Age	
Older	

45. Are your children currently: *Please tick the correct answer*

a. Living with you in Canada ❒
b. Living in the Philippines ❒
c. Other (Please specify) ❒

46. What is your current immigration status in Canada?

a. Temporary work permit ❒
b. Landed Immigrant ❒
c. Canadian Citizen ❒
d. Other (Please specify) ❒

Do you have anything else you would like to add?

Thank you for your participation in this study

Appendix F: Focus Group Interview Topic Guide

Pilot Project: Questionnaire Development

1. I would like to begin by asking you what was your overall impression of the questions on the questionnaire (prompts: did you find the questionnaire too long, repetitive, well organized etc..)

2. Did you find any of the questions confusing? (prompt: for example, were you unsure what a particular question was asking?)

3. Were there any questions that you felt should not be on the questionnaire?

4. Were there any additional questions that you feel should be included in the questionnaire?

5. Were there any words used on the questionnaire that you did not understand?

6. Do you have any other comments or suggestions for how the questions on the questionnaire could be improved?

7. Anything else you would like to add?

Thank you for participation.

Appendix G: Ethics Approval – Queen Margaret University

Queen Margaret University
EDINBURGH

Name: Catherine Baxter
Status: PhD Student
Subject Area: IIHD
School: Health Sciences

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Email: lclapson@qmu.ac.uk

5 February 2013

Dear Catherine

Ethical Approval – Philippine Nurse Migration to Western Canada: Challenges and Opportunities

Thank you for your response to the letter I sent you following consideration of your application by the Research Ethics Panel.

Dr Jane McKenzie, Convener of the Panel, has reviewed your response to the points you were required to address, and has confirmed that she is happy to take Convener's Action to grant full ethical approval for your research.

A standard condition of this ethical approval is that you are required to notify the Panel, in advance, of any significant proposed deviation from the original protocol. Reports to the Committee are also required once the research is underway if there are any unexpected results or events that raise questions about the safety of the research. The appropriate form is available on the Quality Enhancement Unit website here: (MS Word).

We would like to thank you for your co-operation and wish you well with your project.

Yours sincerely

Lucy Clapson
Secretary to the Research Ethics Panel

Appendix H: Ethics Approval– Red River College

RED RIVER COLLEGE
OF APPLIED ARTS, SCIENCE AND TECHNOLOGY

RESEARCH ETHICS BOARD

CERTIFICATE OF APPROVAL

PRINCIPAL RESEARCHER	DEPARTMENT	NUMBER
Catherine Baxter	Nursing, RRC	**2012/13-09**

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT
Red River College

CO- RESEARCHERS
Dr. Jim Buchan; Dr. Barbara McPake

SPONSORING AGENCIES
N/A

TITLE:
Pilot Project – Questionnaire Development Philippine Nurse Migration in western Canada: Challenges and Opportunities

APPROVAL DATE	TERM (YEARS)	AMENDMENT	AMENDMENT APPROVED	ANNUAL REPORT/ RENEWAL DUE DATE
February 26, 2013	One			February 26, 2014

CERTIFICATION

The protocol describing the above-named project has been reviewed by the Red River College Research Ethics Board and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval of the Research Ethics Board by:
Ashley Blackman, Chair

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures.

Appendix I: Email Invitation and Information Sheet

Invitation and Information Sheet

Hello, my name is Catherine Baxter and I am a post graduate student from the Institute of Health and Development and School of Health at Queen Margaret University in Edinburgh, Scotland. As part of my degree course, I am undertaking a research project for my PhD dissertation. **The title of my project is: Philippine Nurse Migration to Western Canada: Challenges and Opportunities.**

If you are:

An internationally educated nurse from the Philippines and arrived in Canada after January 2008

> **You are invited to share your story about becoming a nurse in Canada. To share your experiences please click on the link below to complete an online survey**.

Survey Link

If you prefer, a written copy of questionnaire can be mailed to you. If you would like to learn more about the study or would like to receive a written copy of the questionnaire please contact me at:

Catherine Baxter cbaxter1@qmu.ac.uk or by phone in Canada 204-996-3473

A little more about the study:

This study will explore the integration of Registered Nurses from the Philippines into the Western Canadian health workforce as Health Care Aides (HCA's), Licensed Practical Nurses (LPNs) and Registered Nurses (RNs).

There may be no benefit to you personally in taking part in this research but the findings of the project will be valuable because it will help guide the development of future programs for IENs and better inform policy makers on the issues IENs face entering and integrating into the Western Canadian health workforce.

All data will be anonymised as much as possible, but you may be identifiable from your email address or contact information provided. Your name will be replaced with a participant number, and it will not be possible for you to be identified in any reporting of the data gathered.

The results may be published in a journal or presented at a conference.

If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact: **Dr. Tom Harrigan by email: tharrigan@rrc.ca or by phone: 204-632-2269 (In Canada) or by mail: Red River College, C608- 2055 Notre Dame, Winnipeg, Manitoba, Canada, R3H OJ9**

Thank you

Catherine Baxter

Post Graduate Student, Institute of International Health and Development and School of Health
Queen Margaret University, Edinburgh

Appendix J: Informed Consent

Queen Margaret University
EDINBURGH

Consent Form

Philippine Nurses Migration to Western Canada: Challenges and Opportunities

I have read and understood the information sheet and this consent form. I have had an opportunity to ask questions about my participation.

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

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

Name of participant: _____

Signature of participant: _____

Signature of researcher:_____

Date: _____

Contact details of the researcher

Name of researcher: Catherine Baxter

Address: Post Graduate Student, Institute of International Health and Development, School of Health.
Queen Margaret University, Edinburgh
Queen Margaret University Drive
Musselburgh
East Lothian EH21 6UU

Email / Telephone: cbaxter1@qmu.ac.uk / Phone: 204-632-2506 (In Canada)

Appendix K: Use of Red River College Survey System

From: Ashley Blackman
Sent: Friday, November 09, 2012 3:45 PM
To: Catherine Baxter
Subject: Use of College Survey System

Hello Catherine:

In response to your request to use the College's survey system here is some information. The College follows the policies and procedures described by the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS). (Canadian Institutes of Health Research (CIHR), the Natural Sciences and Engineering Research Council of Canada (NSERC) and the Social Sciences and Humanities Research Council of Canada (SSHRC).

For internal surveys of staff and students, the College uses a survey system known as Vovici. This software is hosted on a College server behind a firewall.

The survey software is ordinarily set not to record uniquely personal information, such as the email address of a respondent. Since, you are interested in conducting a follow-up survey of respondents. The questionnaire will ask respondents explicitly for permission prior to presenting questions seeking to obtain contact information.

Unless permission is formally given to others, only three staff in the Research & Planning office have access to the survey data. The office itself is secured behind a door which is locked when staff are not present because we store other confidential documents in the office. (Upon completion of the fielding of your instrument, Research & Planning staff will send you a password protected zipped SPSS file.) The data will be stored on our server until we are instructed to destroy the file.

If you have any questions about this information please let me know.

Mr. Ashley Blackman,
Chair Research Ethics Board, and
Director, Research and Planning
Red River College
C509-2055 Notre Dame,
Winnipeg, MB
Canada
R3H 0J9

Voice: (204) 632 - 2091

Appendix L: Framework Analysis - Thematic Chart Example: Post-Employment Challenges

Theme 6: Post-Employment Challenges			
	Negative Attitudes of Others		
Case	Racism	Bullying	Not Supportive
RN			
Patricia	Small Town – Asian [93] questioning abilities [178] Patients & Nurses Response to: [183]	[177]	[136]
Angelica			Senior nurses not supportive new hires [110] Minimize questions [115]
Grace			Unsupportive [108]
Anna	Racism [83] Witnessed Patients to others (HCAs) [89]		
Joseph	Clients [86]		Look down on you [82]
Michelle	Nurses respected Philippines [110] Pts abuse system/staff [121]	Senior Staff bully [151]*	
Hannah			Hard time [149]
Christopher	Cdn nurses not used to different cultures [59]	Experienced a little bit of bullying [136]	
Bea			
Jennifer	More racism Canada than UK [186]		Don't respect experience [128] Sarcastic response to questions [176]

Appendix M: Framework Analysis -Example: Codes to Categories

Theme Six: Post Employment Challenges

Codes	Categories	Sub-Theme	Theme

• Procedures & Protocols
• Skills
• Knowledge
  ○ Health Assessment
  ○ Medications
  ○ Equipment & Technology
  ○ Client populations
  ▪ Indigenous
  ▪ Geriatric
	Knowledge and Skills	Knowledge & Skills	Adjusting to Nursing Practice in Canada

• English Language skills • Accent of others	English Language Skills	Language & Sociocultural Communication	

• Idioms
• Communication with patients
• Communication with families
• Communication with IDT
  ○ Assertiveness
  ○ Delegation
	Sociocultural Communication		

• Patient: Nurse Ratios • Sick Calls	Human Resources	Working with Different Resources	
• Health Care Funding – Canada • Health Care Funding - Philippines	Financial Resources		

• Different Approach to:
  ○ Elder Care
  ○ Pain Management
  ○ Palliative Care
	Philosophy of Care	Conflicting Values	

• Hours of work • Endorsements	Sense of Duty		
• Scope of practice • Interdisciplinary practice	Roles & Responsibilities	Autonomous & Collaborative Practice	
• LPN vs RN responsibilities	Role Ambiguity		

Appendix N: Abbreviations

Countries

United Kingdom (U.K.)

United States of America (U.S.)

Health Workforce

Health Care Aide (HCA)

Health Human Resource (HHR)

Internationally Educated Nurse (IEN)

Internationally Educated Health Professional (IEHP)

Internationally Educated Medical Graduates (IMG)

Licensed Practical Nurse (LPN)

Registered Nurse (RN)

Unregulated Health Worker (URHW)

Nursing Regulatory bodies

College and Association of Registered Nurses of Alberta (CARNA)

College of Licensed Practical Nurses of Alberta (CLPNA)

College of Licensed Practical Nurses of Manitoba (CLPNM).

College of Registered Nurses of Manitoba (CRNM)

Saskatchewan Association of Licensed Practical Nurses (SALPN)

Saskatchewan Association of Registered Nurses (SRNA)

Organizations, Associations & Institutes

Advisory Committee on Health Delivery and Human Resources (ACHDHR)

Alberta Health Services (AHS)

Canadian Institute of Health Information (CIHI)

Canadian Association of Schools of Nursing (CASN)

Canadian Nurses Association (CNA)

Human Resources and Skills Development Canada (HRSDC)

International Council of Nurses (ICN)

Manitoba Nurses Union (MNU)

National Health Service (NHS)

Philippine Nurses Association of Manitoba (PNAM)

Philippines Overseas Employment Agency (POEA)

Queen Margaret University (QMU)

Red River College (RRC)

Winnipeg English Language Assessment and Referral Centre (WELARC)

World Health Organization (WHO)

Regulatory Requirements

Canadian English Language Benchmark Assessment for Nurses (CELBAN)

Canadian Practical Nurses Registration Exam (CPNRE)

Canadian Registered Nurse Exam (CRNE)

Clinical Competency Assessment (CCA)

Foreign Credential Recognition (FRC)

International English Language Testing System (IELTS)

International Qualification Assessment Service (IQAS)

National Council Licensure Exam (NCLEX)

Substantially Equivalent Competence Assessment (SEC)

Other Abbreviations in Alphabetical Order

Canadian Experience Class (CE)

Clinical Resource Nurse (CRN)

Complete Blood Count (CBC)

Exchange Visitor Program (EVP)

Framework Analysis (FA)

Intravenous (IV)

Live-in Caregiver Program (LCP)

Memorandum of Understanding (MOU)

Non-Steroidal Anti-inflammatory drugs

Percutaneous endoscopic gastrostomy (PEG)

Provincial Nominee Program (PNP)

Statistical Package for the Social Sciences (SPSS)

Temporary Foreign Worker (TFW)