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Playing the game: A grounded theory study of the integration of internationally qualified nurses in the Australian healthcare system

Thesis submitted by

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In fulfilment for the requirements for the degree of Doctor of Philosophy (Health)

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Co-Author Agreement

Thesis Title: Playing the game: A grounded theory study of the integration of internationally qualified nurses in the Australian healthcare system			
Name of Candidate: Ylona CHUN TIE	**Details of publication(s) on which chapter is based**	**Nature and extent of the intellectual input of each author, including the candidate**	**I confirm the candidate's contribution to this paper and consent to the inclusion of the paper in this thesis**
Chapter 2	Chun Tie, Y., Birks, M., & Mills, J. (2018). The experience of internationally qualified registered nurses working in the Australian healthcare system: An integrative literature review. *Journal of Transcultural Nursing,29(3),* (pp. 274-284). doi:10.1177/1043659617723075	Chun Tie conducted the integrated literature review. Chun Tie assessed the methodological rigor of the eligibility of each article using the Critical Appraisal Skills Programme (2015) appraisal checklist appropriate for the relevant research design Chun Tie wrote the first draft of the paper which was revised with editorial input from Birks and Mills. Chun Tie, Birks and Mills approval of final version.	Name: Professor Melanie Birks Signature: Name: Professor Jane Mills Signature:
Chapter 3	Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice nurse researchers. *SAGE Open Medicine, 7*, 1-8. doi:10.1177/2050312118822927	Chun Tie designed the study. Chun Tie developed the design framework which was revised by Birks. Chun Tie wrote the first draft of the paper which was revised with editorial input from Birks and Francis. Chun Tie, Birks and Francis approval of final version.	Name: Professor Melanie Birks Signature: Name: Professor Karen Francis Signature:
Chapter 5	Chun Tie, Y., Birks, M., & Francis, K. (2018) Playing the game: A grounded theory of the integration of international nurses. *Collegian*. doi:10.1016/j.colegn.2018.12.006	Chun Tie designed the study. Chun Tie collected the data and performed the coding and data analysis with assistance from Birks and Francis. Chun Tie wrote the first draft of the paper which was revised with editorial input from Francis and Birks. Chun Tie completed a report using the Consolidated Criteria for Reporting Qualitative Research (COREQ): a 32-item checklist for interviews and focus groups. Chun tie, Birks and Francis approval of final version.	Name: Professor Melanie Birks Signature: Name: Professor Karen Francis Signature:

Dedication

I dedicate this thesis to my late mother Maria, who inspired me to be strong in the face of adversity, *Ik mis je*, and to my father Dolf, who encouraged and nurtured my love of debating all things philosophical, *mijn dankbaarheid dank u zeer*. I am grateful to my partner Paull for his belief and unwavering support, including the travel opportunities that broadened my horizons. This thesis is dedicated to my four children, Jay, Tristan, Joel and Leteisha, who inspire and motivate me daily, as well as my daughters-in-law, Cherie and Mel, and my son-in-law, Liborio, for their love, encouragement and understanding. Finally, I am grateful to my grandsons, Seth, Jett, Xander and Kobe, whose galvanising words 'so Glam-ma, does that mean you are going to be a doctor and a nurse?' inspired me to keep going during the demanding times. I could not let them down.

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'Nothing in life is to be feared. It is only to be understood'

Marie Curie, Polish-born French physicist and chemist, first recipient of two Nobel prizes, first female professor, University of Paris

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Finally, to my fellow nurse colleagues, this is for each of us.

Statement of Originality

I declare that this thesis is my own work and has not been submitted in any form for another degree or award at any university or other institution of tertiary education. Information derived from the published or unpublished work has been acknowledged in the text and a list of references is given.

________________________ February 2019

Signature Date

Ylona CHUN TIE

Name

Statement of Access

I, the undersigned, the author of this thesis, understand that James Cook University will make this thesis available for use within the university library and allow access to users in other approved libraries.

________________________ February 2019

Signature Date

Ylona CHUN TIE

Name

Copyright Declaration

Every reasonable effort has been made to gain permission and acknowledge the owners of copyright material included in this thesis. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

________________________ February 2019

Signature Date

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Name

Statement of Contribution of Others

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College of Health and Medicine, University of Tasmania, Australia

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College of Healthcare Sciences, James Cook University, Australia

Professor Jane Mills

College of Health—Te Kura Hauora Tangata, Massey University, New Zealand

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Abstract

Background

Twenty-nine per cent of registered nurses in Australia received their first nursing qualification in a country other than Australia. Therefore, understanding the process of successfully transitioning internationally qualified nurses into a foreign healthcare system is vital to ensure the provision of safe, quality nursing care for all Australians.

Aim

The aim of this study was to explore how internationally qualified registered nurses and Australian qualified registered nurses adapt to working together in the Australian healthcare system and develop a theory that explains this process.

Research question

What is the process by which internationally qualified registered nurses are integrated into the Australian healthcare system?

Methodology

Grounded theory methodology was used in this study. Concurrent data collection/generation and analysis of online survey data (n = 186) and individual participant interviews (n = 15) was undertaken. Storyline was used as a technique of advanced analysis to integrate and present the theory. Two focus groups (n = 9 and n = 7) were held to evaluate and validate the theory.

Findings

International and Australian nurses work together to enable the successful integration of international nurses into practice. Four phases underpin professional socialisation, enculturation and adaption to the cultural norms of the workplace: (i) joining the game: adapting to context—observing and learning the cultural norms; (ii) learning the game: becoming socialised—receiving support; (iii) playing by the rules: aligning scope—communicating for quality care; and (iv) the end game—integration. These phases

interconnect to form the final theory of ‘playing the game’—a grounded theory of the integration of international nurses in the Australian healthcare system.

Discussion

Nurse migration trends to Australia have seen an increase in international nurses from developing countries. Context of the work milieu as the dynamic playing field is instrumental in understanding how authentic leadership and positive work environments support integration processes. Consequences for unsuccessful integration are significant and result in: negative work environments; patient dissatisfaction; adverse events; damaged reputations of registered nurses, organisations and the profession; and loss of skilled and experienced registered nurses from the profession.

Conclusion

The findings of the research are significant for the nursing workforce in Australia in relation to the recruitment, retention and integration of experienced registered nurses. Promotion of cultural responsiveness education and integration strategies prevents the attrition of experienced registered nurses. Recommendations are made to inform policies and practices for sustaining a workforce that will provide quality nursing care for all Australian citizens, regardless of the place of origin of the nurse or where they obtained their initial nursing qualification.

Key Words

Australia; Healthcare Systems; Grounded Theory; Integration; Nurses, International; Storyline.

MeSH terms

Acculturation; Humans; International Cooperation; Mentors; Nurses, International/og [Organization & Administration]; Nurses, International/sd [Supply & Distribution]; Organizational Objectives; Personnel Selection/og [Organization & Administration]

MeSH HEADING

AUSTRALIA

ATTITUDE OF HEALTH PERSONNEL

CULTURAL DIVERSITY

EMIGRATION AND IMMIGRATION

EMIGRANTS AND IMMIGRANTS

FOREIGN PROFESSIONAL PERSONNEL

INTERNATIONALITY

NURSES

NURSES INTERNATIONAL

NURSING STAFF

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Table of Abbreviations

Abbreviation	Full name
ABS	Australian Bureau of Statistics
ACN	Australian College of Nursing
ACSQHC	Australian Commission on Safety and Quality in Health Care
AH	Allied health
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AMC	Australian Medical Council
ANMAC	Australian Nursing and Midwifery Accreditation Council
AQRN	Australian qualified registered nurse
CaLD	Culturally and linguistically diverse
CCN	Critical care nurse
CoNNMO	Coalition of National Nursing & Midwifery Organisations
ESL	English as a second language
EU	European Union
GFC	Global Financial Crisis
GT	Grounded Theory
GTM	Grounded Theory Methodology
HCP	Healthcare professional
HREC	Human Research Ethics Committee
HWA	Health Workforce Australia (abolished 8 October 2014)
ICN	International Council of Nurses
ICNM	International Centre on Nurse Migration
ICT	Information and communication technology
IMG	International Medical Graduate
IQRN	Internationally Qualified Registered Nurse
JCU	James Cook University
MRPQ	Mutual Recognition of Professional Qualifications
NCLEX	National Council Licensure Examination
NDIS	National Disability Insurance Scheme

Abbreviation	Full name
NESB	Non-English-speaking background
NHWDS	National Health Workforce Data Set
NMBA	Nursing and Midwifery Board of Australia
NP	Nurse practitioner
NSQHS	National Safety and Quality Health Service Standards
NUM	Nurse unit manager
OECD	Organisation for Economic Co-operation and Development
PCC	Person-centred care
RN	Registered nurse
TEQSA	Tertiary Education Quality and Standards Agency
UK	United Kingdom
US	United States of America
WHO	World Health Organization

Key Terms and Definitions

Term	Definition
457 Visa	Subclass 457 Temporary Work (Skilled) visa Note: On 18 April 2017, the Government announced that the Temporary Work (Skilled) visa (subclass 457 visa) would be abolished and replaced with the Temporary Skill Shortage visa in March 2018 (Department of Home Affairs, 2017).
Adaptation	The act of adapting behaviour.
Allied health (AH)	'Allied health is a term used to describe the broad range of health professionals who are not medical practitioners, dentists or nurses' (Health Times, 2017).
Aboriginal and Torres Strait Islanders	In this document, the term 'Aboriginal and Torres Strait Islanders' is used wherever possible, and the term 'Indigenous' is also respectfully used at times when it is more appropriate to the context.
Australian Bureau of Statistics (ABS)	'The ABS purpose is to inform Australia's important decisions by partnering and innovating to deliver relevant, trusted, objective data, statistics and insights'. 'The ABS is Australia's national statistical agency, providing trusted official statistics on a wide range of economic, social, population and environmental matters of importance to Australia' (ABS, 2018).
Australian Commission on Safety and Quality in Health Care (ACSQHC)	'The Australian Commission on Safety and Quality in Health Care (the Commission) was initially established in 2006 by the Australian, state and territory governments to lead and coordinate national improvements in safety and quality in health care' (ACSQHC, 2019).
Australian Health Practitioner Regulation Agency (AHPRA)	Australian Health Practitioner Regulation Agency is 'the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia. Supports the National Health Practitioner Boards (such as the Nursing and Midwifery Board Australia) in implementing the scheme' (ANMAC, 2012, p. 20).
Australian Institute of Health and Welfare (AIHW)	'The Australian Institute of Health and Welfare produces high-quality reports and other information products, on key health and welfare issues in Australia. These are used to improve the delivery of health and welfare for Australians' (AIHW, 2019).
Australian Medical Council (AMC)	'The AMC's purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community. The Australian Medical Council (AMC) is an independent national standards body for medical education and training' (AMC, 2019).
Australian Multicultural Council (AMCC)	'The Australian Multicultural Council is a ministerially appointed body representing a broad cross-section of Australian interests that provides independent and robust advice to Government on multicultural affairs, social cohesion and integration policy and programs' (Department of Home Affairs, 2019).

Term	Definition
Australian Nursing and Midwifery Accreditation Council (ANMAC)	‘The Australian Nursing and Midwifery Accreditation Council is the independent accrediting authority for nursing and midwifery under the National Registration and Accreditation Scheme. ANMAC sets standards for accreditation and accredits nursing and midwifery programs leading to registration and endorsement; and the providers of those programs’ (ANMAC, 2012, p. 20). In addition, the ANMAC is an independent organisation gazetted by the Minister for Immigration (pursuant to the *Migration Act 1958, Regulations Amendment 1999, 2.228*) to perform skills assessment for migration purposes. ANMAC assesses the skills of internationally qualified nurses and midwives who want to migrate to Australia under the General Skilled Migration program (NMBA, 2018c).
Australian Qualified Registered Nurse (AQRN)	An AQRN is defined as a registered nurse who received their first nursing qualification to practice as a nurse in Australia.
Bologna Declaration	‘The Bologna Declaration aims to harmonize European higher education’ (Patricio, den Engelsen, Tseng, & Ten Cate, 2008, p. 597).
Clinical workforce	‘The nursing, medical and allied health staff that provides patient care and students who provide patient care under supervision. This may also include laboratory scientists’ (ACSQHC, 2011, p. 8).
Clinician	‘A clinician is a person who spends the majority of his or her time working in the area of clinical practice’ (AIHW, 2016b, p.3). ‘Clinicians include registered and non-registered practitioners, or a team of health professionals providing health care who spend the majority of their time providing direct clinical care’ (ACSQHC, 2011, p. 8).
Code of conduct for nurses	The code sets out ‘the legal requirements, professional behaviour and conduct expectations for all nurses in all practice settings’ in Australia (NMBA, 2018a).
Collaborative practice	‘Where health professionals work as an effective team, optimising individual skills and talents and sharing case management to reach the highest of patient care standards’ (ANMAC, 2012, p. 20).
Communities of practice	‘Social participation as a process of learning and knowing’ (Wenger, 1998, pp. 4–5).
Competence	Competence is defined as ‘the combination of skills, knowledge, attitudes, values and abilities underpinning effective and/or superior performance in a profession or occupational area’ (ANMAC, 2012, p. 20).
Competent	‘When a person is competent across all the domains of competencies applicable to the nurse or midwife, at a standard judged to be appropriate for the level of nurse being assessed‘ (ANMAC, 2012, p. 20).

Term	Definition
Context of practice	The setting/environment where competence can be demonstrated or applied. 'The conditions that define an individual's nursing and/or midwifery practice'. These include: 'The type of practice setting, the location of the practice setting, the characteristics of patients, the focus of nursing and/or midwifery activities, the degree to which practice is autonomous, and the resources that are available, including access to other healthcare professionals' (Nursing and Midwifery Board of Australia [NMBA], 2016c, p. 2).
Culturally congruent practice	'Culturally congruent practice is the application of evidence-based nursing that is in agreement with the preferred cultural values, beliefs, worldview and practices of the healthcare consumer and other stakeholders. Cultural competence represents the process by which nurses demonstrate culturally congruent practice. Nurses design and direct culturally congruent practice and services for diverse consumers to improve access, promote positive outcomes, and reduce disparities' (ANA, 2015, p. 31).
Cultural humility	When we 'engage in self-reflection, learning our own biases, being open to others' cultures, and committing ourselves to authentic partnership and redressing power imbalances' (Minkler, 2012, p. 6).
Cultural tolerance	Cultural tolerance is 'recognizing and respecting other's beliefs and practices without sharing in them' (Neufeldt, 1994, p. 11).
Department of Health (DoH)	'The Department of Health has a diverse set of responsibilities, but throughout there is a common purpose, which is reflected in our Vision statement: Better health and wellbeing for all Australians, now and for future generations. We aim to achieve our Vision through strengthening evidence-based policy advice, improving program management, research, regulation and partnerships with other government agencies, consumers and stakeholders' (Department of Health, 2019).
Discrimination	'Discrimination is the unjust treatment of one or more person/s based on factors such as race, religion, sex, disability or other grounds specified in anti-discrimination legislation' (Australian Human Rights Commission, 2018).
Education provider	'University, or other higher education provider, responsible for a program of study, the graduates of which are eligible to apply to the NMBA for nursing or midwifery registration or endorsement' (ANMAC, 2012, p. 21).
Enculturation	'Enculturation is the process by which an individual learns the traditional content of a culture and assimilates its practices and values' (Merriam Webster, 2009).
Graduate nurse	Student who has completed a Diploma or Bachelor of Nursing.
Healthcare	Healthcare is defined 'as being composed of health care systems and actions taken within them designed to improve health or well-being' (Campbell, Roland, & Buetow, 2000, p. 1612).
Health system	'A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities' (World Health Organization [WHO], 2007).

Term	Definition
Health Practitioner Regulation National Law Act 2009	'Health Practitioner Regulation National Law Act 2009 (National Law)—contained in the Schedule to the Act. This second stage legislation provides for the full operation of the National Registration and Accreditation Scheme for health professions from 1 July 2010 and covers the more substantial elements of the national scheme, including registration arrangements, accreditation arrangements, complaints, conduct, health and performance arrangements, and privacy and information-sharing arrangements. The purpose is to protect the public by establishing a national scheme for regulating health practitioners and students undertaking programs of study leading to registration as a health practitioner. The National Law is legislated in each state and territory. The Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008 outlines the administrative arrangements established under the first stage of the National Registration and Accreditation Scheme for the Health Professions (Act A)' (ANMAC, 2012, p. 21).
Health Workforce Australia (HWA)	In the 2014 Budget, the Australian Government announced the closure of Health Workforce Australia (HWA). HWA closed on 6 August 2014 and the essential functions were transferred to the Department of Health (DoH). The HWA website has been archived in Pandora—an archiving website managed by the National Library of Australia.
Higher education provider	'Tertiary education provider who meets the Higher Education Standards Framework (Threshold Standards) as prescribed by the Tertiary Education Quality and Standards Agency Act 2011 and is currently registered with TEQSA [Tertiary Education Quality and Standards Agency]' (ANMAC, 2012, p. 21).
Hospital	Healthcare facility licensed by the respective regulator as a hospital or declared as a hospital.
International Council of Nurses (ICN)	'The International Council of Nurses (ICN) is a federation of more than 130 national nurse associations (NNAs), representing the more than 20 million nurses worldwide. Founded in 1899, ICN is the world's first and widest reaching international organisation for health professionals. Operated by nurses and leading nurses internationally, ICN works to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce' (ICN, 2019).
International nurse	An international nurse is defined as a nurse who received their first nursing qualification to practice as a nurse in a country other than Australia.
Internationally qualified registered Nurse (IQRN)	A registered nurse who received their first nursing qualification to practice as a nurse in a country other than Australia.
Integration	Integration refers to being incorporated as an equal into society or an organisation of individuals of different groups (as races).
National competency standards for the registered nurse	'The national competency standards for the registered nurse are the core competency standards by which your performance is assessed to obtain and retain your registration as a registered nurse in Australia'. (NMBA, 2006, p. 1). These were superseded by the Registered Nurse Standards for Practice (NMBA, 2016b).

Term	Definition
National Council Licensure Examination (NCLEX)	NCLEX is a nationwide examination for the licensing of nurses in the United States and Canada. There are two types, the National Council Licensure Examination for Registered Nurses (NCLEX-RN) and the National Council Licensure Examination for Practical Nurses (NCLEX-PN).
National Health Workforce Data Set (NHWDS)	'The NHWDS is a combination of registration and survey data collected through the registration renewal process for registered health practitioners' in Australia (AIHW, 2018).
Nursing and Midwifery Board of Australia (NMBA)	The national body responsible for the regulation of nurses and midwives in Australia (NMBA, 2017).
Occupational English Test	The Occupational English Test is an English language test for overseas-educated health practitioners applying to practice in Australia. The updated Occupational English Test came into effect on 9 September 2018.
Organisational support	Refers to the input and activities from executive, committees and organisational leaders that demonstrate commitment to best practice and facilitate optimum patient care through provision of resources, staff consultation and support.
Orientation	'A formal process of informing and training workforce upon entry into a position organization, which covers the policies, processes and procedures applicable to the organization' (ACSQHC, 2011, p. 11).
Patient	A person receiving healthcare. Synonyms for 'patient' include 'consumer' and 'client' (ACSQHC, 2011, p. 11).
Patient-centred care	'The delivery of healthcare that is responsive to the needs and preferences of patients. Patient-centred care is a dimension of safety and quality'. (ACSQHC, 2011, p. 11). Synonyms for patient include person and family.
Pearson test of English Academic	The English Test for Study Abroad and Immigration.
Point of care	'The time and location where an interaction between a patient and clinician occurs for the purpose of delivering care' (ACSQHC, 2011, p. 11).
Policy	'A set of principles that reflect the organisation's mission and direction. All procedures and protocols are linked to a policy statement' (ACSQHC, 2011, p. 11).
Practice	'Practice means any role, remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. Practice in this context is not restricted to the provision of direct clinical care. It also includes using professional knowledge (working) in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on the safe, effective delivery of services in the profession' (NMBA, 2016b).

Term	Definition
Professional development	'The establishment of higher levels of competence in the range of knowledge and skills needed to perform duties or support interventions, be they in clinical practice, management, education, research, regulation or policy-making' (International Council of Nurses, 2010, p. 2).
Quality of care	Quality of care for individuals defined by Campbell et al. (2000, p. 1614) as 'whether individuals can access the health structures and processes of care which they need and whether the care received is effective'.
Registered nurse (RN)	An RN is 'a person who has completed the prescribed educational preparation, demonstrates competence to practise and is registered under the Health Practitioner Regulation National Law as a registered nurse in Australia' (NMBA, 2016b).
Registered Nurse standards for practice	Standards for practice are the expectations of registered nurse practice. They inform the education standards for registered nurses, the regulation of nurses and determination of the nurse's capability for practice, and guide consumers, employers and other stakeholders on what to reasonably expect from a registered nurse regardless of the area of nursing practice or years of nursing experience (NMBA, 2016b). These replace the previous National Competency Standards for the Registered Nurse (NMBA, 2006).
Skill mix (nursing)	The combination of different categories of staff providing nursing care within a setting.
Scope of practice	'Scope of practice is that in which nurses are educated, competent to perform and permitted by law. The actual scope of practice is influenced by the context in which the nurse practises, the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider' (NMBA, 2016b, p. 6).
Social capital	Social capital is defined by the OECD as 'networks together with shared norms, values and understandings that facilitate co-operation within or among groups' (OECD, 2001, p. 41). 'Social capital consists of structural features (bonding, bridging and linking) and relational cognitive norms that enable people to work collectively to solve problems and achieve common goals' (Hofmeyer & Marck, 2008, p. 145).
Social determinants of health	'The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries' (WHO, 2018c).
Sociocultural discord	The basic social psychological problem of being different and not fitting in.
Student in nursing (SIN)	An undergraduate student in nursing is a student nurse who is employed but is also studying at a recognised university.

Term	Definition
Tertiary Education Quality and Standards Agency (TEQSA)	TEQSA was ‘established in July 2011 to regulate and assure the quality of Australia’s large, diverse and complex higher education sector. From January 2012, the TEQSA will register and evaluate the performance of higher education providers against the new Higher Education Standards Framework. TEQSA will undertake compliance assessments and quality assessments’ (ANMAC, 2012, p. 23).
Test of English as a foreign language internet-based test	Test of English as a foreign language internet-based test (revised October 2017 to a paper-and-pencil test).
Transition	The process through which people move.
Workforce	‘People employed by a health service organisation’ (ACSQHC, 2011, p. 12).
Workplace experience	The 2012 ANMAC Registered Nurse Accreditation Standards define workplace experience as ‘a component of nursing education which allows students to use judgment when applying theoretical knowledge in an actual practice setting. Includes concept of “clinical training” as set out under National Law’ (ANMAC, 2012, p. 23).
Workplace environment	‘The overall surroundings and conditions where healthcare is being delivered, including the building, fixtures, fittings and services such as air and water supply. Environment can also include other patients, visitors and the workforce’ (ACSQHC, 2011, p. 8).
World Health Organization (WHO)	The WHO is the directing and coordinating authority on international health within the United Nations’ system (WHO, 2016).

Chapter 1: Introduction

Few studies have examined the process underpinning the successful integration of international nurses specifically from a host country perspective. This chapter introduces the impetus for this study and the subsequent catalyst that moved the research forward. A grounded theory methodology (GTM) was adopted to investigate the integration and adaption process used by internationally qualified registered nurses (IQRNs) and Australian qualified RNs (AQRNs) to work together in the Australian healthcare system. This chapter presents an overview of the nursing profession to establish a context for the study. It concludes with an overview of the thesis outline.

1.1 Impetus for the study

My interest in understanding how diverse nursing teams work together stemmed from personal experience working in the Australian healthcare sector. During my nursing career I held various roles and positions, including registered nurse (RN), clinical nurse, team leader, after-hours hospital nurse manager and lecturer in the tertiary education sector. These roles involved working with nurses, including internationally qualified nurses. My partner worked in the United Arab Emirates; therefore, I had opportunities to visit hospitals and speak face to face with nurses, clinical educators and directors of nursing in Dubai. The nursing workforce in Dubai is culturally and ethnically diverse: less than 5% of nurses are Emirati nationals. I observed the multicultural nature of the nursing workforce and how teams were predominately composed of nurse managers and clinical nurse educators from developed countries such as the United States (US), Canada, the United Kingdom (UK) and Australia, as well as bedside nurses from the Philippines and India.

The catalyst for this study was an incident I experienced as a university lecturer coordinating and teaching postgraduate nursing courses in Australia. RNs enrolled in these courses were required to be employed in an approved intensive care or cardiac coronary care unit. The clinical component of the assessment was conducted by the clinical nurse educator in the unit in which the postgraduate student was working. A clinical nurse educator contacted the postgraduate subject coordinator regarding their view that certain international nurses from a non-English-speaking background (NESB) should not be permitted to pass the course. This

facility had recruited a large number of international nurses. As a university educator, I was made aware that the clinical nurse educators perceived that the international nurses did not possess the right attributes or commitment to quality person-centred care (PCC) and were only seeking to advance their careers with academic certificates.

This caused me to reflect: Was this a case of racism? Did the nurses have a preference for who they worked with? What else was going on here? This was not the first time I had heard nurses expressing concerns about working with some international nurses. I wondered why the clinical nurse educators felt so strongly about this group of international nurses, most of whom came from southern India. This in turn led me to question whether this was an isolated incident or whether it was occurring more broadly.

As an RN, I understand that the repercussions of dysfunctional nursing teams are serious and can adversely affect patient safety, positive work environments, delivery of quality nursing care and retention of experienced RNs. Consequently, I concluded that an important area of study was to understand the process of transition and adaption—in particular, how domestic nurses adapt to working with IQRNs.

Grounded theory was selected as the methodology to underpin this study and is introduced in Chapter 3. However, before commencing a research study using GTM, the researcher must determine their philosophical position—that is, establish their worldview or philosophical stance and their values and beliefs regarding how knowledge is acquired and constructed.

1.2 Philosophical position

Philosophical position is defined as ‘personal beliefs about reality that guide thinking about how legitimate knowledge can be acquired’ (Birks & Mills, 2015, p. 179). Each methodology is established on a particular philosophy of thought that includes concepts of ontology (the study of the nature of reality) and epistemology (the nature of justifiable knowledge). Our ontological and epistemological perspectives shape our understanding of how we view the world and how we acquire knowledge. Clarifying our personal philosophical position requires us to be reflexive and to identify our beliefs about reality and the influence of our thought processes around how legitimate knowledge is acquired and constructed (Birks, 2014).

Reflexivity is the 'active, systematic process used by the researcher in order to gain insight into their work that will guide future actions and interpretations' (Birks & Mills, 2015, p. 180). Consequently, reflexivity can be practiced by listening beyond our differences to construct 'a new set of shared assumptions' or a preparedness to 'remain open' to diverse viewpoints (Hesse-Biber, 2010, p. 418).

Beginning researchers often struggle to find their philosophical position, and the lead author found this to be a challenging process. They had not previously considered how they acquired knowledge or explored how they viewed the world. Does the author's interpretation of texts change depending on their view of history and their background, experiences, knowledge and personal reflections? As the author reflected on and responded to these questions, many factors encompassed in philosophical inquiry were uncovered. The author used the technique of diagramming to present a visual understanding of the components of philosophical inquiry in the context of this study. These factors are explored in detail in Chapter 3. The next section provides a synopsis of the background to this study.

1.3 Existing knowledge (background)

The nursing profession forms the largest sector of the healthcare workforce at the local, national and international levels. The Australian nursing workforce comprises two tiers: RNs and enrolled nurses. Enrolled nurses work under the direct supervision of an RN and have a different scope of practice. They can undertake further education to become a nurse practitioner (NP) or a credentialed RN in a specialty practice such as mental health. In Australia, RNs play a pivotal role in providing quality evidence-based, PCC to diverse patients, families and communities. They coordinate the provision of healthcare and make substantive contributions to health promotion and prevention, education, clinical practice, leadership and interprofessional collaboration. RNs work across the continuum of care in a variety of settings, including acute care, hospitals, communities, hospices and schools, as well as public, private, government and non-government organisations. Australia is geographically vast and has a broadly dispersed population (Cosgrave, Maple, & Hussain, 2018), with nurses working in major cities, inner and outer regional areas and remote and very remote areas of the country (Australian Institute of Health and Welfare [AIHW], 2016a).

Healthcare is rapidly evolving and becoming more complex and demanding (Dixit & Sambasivan, 2018). Coupled with this, healthcare professionals and the populations they serve have become more culturally and linguistically diverse (CaLD) (Gillham et al., 2018; Xiao et al., 2017). Cultural and linguistic diversity in the nursing profession and patient populations adds to the complexity of working in dynamic healthcare environments. The provision of safe, quality care to diverse populations relies on adequate staffing and RNs being prepared for changing healthcare systems and caring for and working with multicultural populations (Kalisch & Lee, 2013; Levett-Jones, 2016; Scott, Matthews, & Kirwan, 2014).

A key issue for future nurse workforce planning and policy is the changing demographics of the population. Developed countries are seeing an increase in the ageing population and the ageing nursing workforce (Buchan, Duffield, & Jordan, 2015). In Organisation for Economic Co-operation and Development (OECD) countries, nurses are aged, on average, in their mid-40s (International Centre on Nurse Migration [ICNM], 2015). As these nurses retire from health employment or reduce their full-time equivalent working hours in the coming decades, there will be an increase in the shortage of experienced nurses. Hogan, Moxham and Dwyer (2007) state that 'it is paramount that there is an adequate nursing workforce supply for now and in the future, to achieve equitable and quality health outcomes and consumer access to healthcare, regardless of geographic location' (p. 189).

The prediction of a nursing shortage in Australia by 2025 resulting from an ageing nurse workforce, falling retention rates and health utilisation trends is a major concern for future workforce planning (Buchan, Twigg, Dussault, Duffield, & Stone, 2015; Duffield, Roche, Homer, Buchan, & Dimitrelis, 2014; Health Workforce Australia [HWA], 2012). The projected shortfall of 85,000 nurses in 2025 is expected to increase to 123,000 nurses by 2030 (HWA, 2014). This will be exacerbated by increases in life expectancy, ageing populations and the rate of chronic disease presentations. Recognition of these issues has led to the continued recruitment of international nurses (Hawthorne, 2014b).

As a global profession, nurses migrate to work internationally—mostly to developed countries such as Australia (Covell, Primeau, & St-Pierre, 2018; Hawthorne, 2014a; Van den Heede & Aiken, 2013; Wolcott, Llamado, & Mace, 2013; Zander, Blümel, & Busse, 2013; Zhou, Roscigno, & Sun, 2016). Australia's attractive lifestyle coupled with nursing shortages worldwide has

resulted in the recruitment of IQRNs to work in the country (Ohr, Jeong, Parker, & McMillan, 2014; Stankiewicz & O'Connor, 2014). RNs have been recruited from many countries to work in the Australian healthcare system—particularly in rural and remote areas (Francis et al., 2016; Francis, Chapman, Doolan, Sellick, & Barnett, 2008; Francis & Mills, 2011; Ng Chok, Mannix, Dickson, & Wilkes, 2017). After the 2008 Global Financial Crisis (GFC), IQRNs were recruited to enter Australia on 457 visas, which is a Temporary Business Entry (Long Stay) Visa (Buchan, Duffield et al., 2015; Hawthorne, 2011).

Before the GFC, 14,950 RNs were sponsored in Australia from 2004/05 to 2008/09, in addition to registered mental health nurses and midwives. Many of these nurses worked in highly dispersed sites. The primary states of sponsorship in 2008/09 were Victoria (1,010), Queensland (780) and Western Australia (750) (Hawthorne, 2011, p. 121).

At present, there is no universal nursing qualification or global registering authority to support the education, migration and recruitment of experienced nurses into areas of need. The Bologna Declaration of 1999 aimed to harmonise European higher education, including nursing education (Watson et al., 2016). Since then, the European Union (EU) has introduced the Professional Card, which is a competency-based EU-wide nurse education program (Keighley, 2016). In the EU, the directive on the recognition of professional qualifications has been undergoing modernisation since 2011 (European Commission, 2012). The various stakeholders involved in these processes 'have different perspectives on the proposed changes' (Merkur, 2014, p.302). Yet the nursing profession remains one of the most mobile professions globally. In the EU, compliance with the European Directive on Mutual Recognition of Professional Qualifications (MRPQ) is the key to patient safety and quality of care (Buchan, Wismar, Glinos, & Bremner, 2014; Kingma, 2006). The MRPQ also acts to safeguard individual nurses who move across countries within the EU (De Raeve, Rafferty, & Barriball, 2016).

The historical and political contexts of nursing, levels and scope of clinical practice, knowledge, skills and approaches to health and illness can vary significantly across countries, cultures and healthcare settings (Kajander-Unkuri, Salminen, Saarikoski, Suhonen, & Leino-Kilpi, 2013). In addition, definitions, language and lexicons used across jurisdictions and international borders lack consistency, making it more difficult to compare key terms (Benton, González-Jurado, &

Beneit-Montesinos, 2014). In Australia, there is no common nomenclature and shared language in competency standards for each of the health professions registered by the Australian Health Practitioner Regulation Agency (AHPRA) (Peddle, Bearman, Radomski, McKenna, & Nestel, 2018).

In Australia, data on nurses and midwives' country of initial qualification were not collected by the AIHW until 2013 (AIHW, 2014), despite IQRNs being a significant part of the Australian nursing workforce for many years (Stankiewicz & O'Connor, 2014). The Australian nursing workforce is represented by nurses from more than 100 countries who provide care to Australians from more than 150 countries and cultures. Historically, nurses migrating to Australia came from English-speaking countries such as the UK, Scotland, Ireland, New Zealand, Canada and the US. However, in more recent times, nurses have migrated from Southeast Asia, Africa, Middle East and the Philippines (Benton et al., 2014). As a result, international nurses migrating to Australia come from increasingly diverse cultural and linguistic backgrounds where English is often a second or third language (AIHW, 2016a).

IQRNs and other healthcare professionals (HCPs) from NESBs face additional challenges integrating into the Australian healthcare workforce and require support early in the process, particularly with the English language and communication style (Philip, Woodward-Kron, Manias, & Noronha, 2018a; Rumsey, Thiessen, Buchan, & Daly, 2016). In Australia, all HCPs are required to communicate proficiently in English for patient safety (Müller, 2016; Nursing and Midwifery Board of Australia [NMBA], 2018b; Rumsey et al., 2016). Further, studies suggest that it is equally difficult for the existing workforce to accommodate international nurses, particularly around the scope of practice and when English is the second or third language (Hawthorne, 2013b; Hawthorne & To, 2013). Collectively, these factors can compromise the quality and safety of patient care and lead to poor patient outcomes and adverse events such as death.

The successful transition of internationally qualified nurses into a host country is a complex issue. In addition, education and support for existing staff is essential for the successful transition of internationally qualified nurses into practice (Ohr et al., 2014). Strategies need to be made available to assist IQRNs' transition into the workforce in the country of destination and to provide safe, quality care (Sherwood & Shaffer, 2014). A robust support

system for these nurses should be based on ethical considerations and a team approach that is linked to strong leadership. AQRNs require education and support to understand cultural differences and to assist IQRNs to integrate successfully into the Australian healthcare system (Ohr et al., 2014). Challenging workplace experiences and poor integration practices contribute to the turnover and attrition of IQRNs, which in turn increases healthcare costs and further exacerbates the nursing workforce shortage (Hayes et al., 2012). The recruitment and retention of IQRNs is a concern because nursing shortages compromise the provision of appropriate, quality nursing care to people and communities (Hogan et al., 2007).

Data from HWA and the AIHW predict that Australia will continue to rely on IQRNs to help meet the healthcare needs of all Australians (AIHW, 2016b; HWA, 2014). Therefore, responsive workforce planning is necessary to reduce staff turnover, attrition and out-migration of RNs, which contribute to workforce instability and increased economic costs (Hogan et al., 2007). Research to support increased policy development and funding determinations is required to improve nurse retention (Buchan, Duffield & Jordan, 2015). Malik and Manroop (2017, p. 383) argue that additional research is needed to understand the socialisation process of international nurses to improve retention:

> Recent evidence suggests that OECD countries such as Canada, the USA, Australia, and others in Western Europe that tend to attract skilled immigrants still struggle to successfully integrate RINs [recent immigrant newcomers] into their workplaces (Nakhaie and Kazemipur, 2013; Yap et al., 2014). This increasingly diverse workforce means greater complexity to employers wishing to tap into this labor pool, especially as it relates to socializing and integrating this group into the workplace (c.f. Malik et al., 2014). Research shows that immigrants face discrimination in the form of underutilization of skills, low earnings, racial segregation, prejudice, and stereotypes (Bauder, 2003; Zikic et al., 2010). Despite recognizing that immigrant socialization is complex and difficult (Jian, 2012; Leong and Tang, 2016), the extant literature has not directly addressed this growing issue (Malik et al., 2014).

The next section provides an outline of the significance of this study to the nursing profession.

1.4 Significance of this study

The world population is projected to reach 9.8 billion in 2050 and 11.2 billion in 2100, placing increased pressure on governments, regulatory authorities and healthcare organisations to prepare a health workforce to meet future demands (United Nations Department of Economic and Social Affairs, 2017). Research on globalisation and migration of RNs is well documented (Hawthorne, 2001; International Council of Nurses, 2018; Kingma, 2007; Muslin, Willis, McInerney, & Deslich, 2015; Nichols, Davis, & Richardson, 2010; Turner et al., 2009; World Health Organization [WHO], 2018b). However, the effect of migration on the health workforce of recipient countries is less well known (Garner, Conroy, & Bader, 2015; Moyce, Lash, & de Leon Siantz, 2016; Salami, Dada, & Adelakun, 2016; Short, Hawthorne, Sampford, Marcus, & Ransome, 2012). Research on internationally qualified healthcare professionals primarily focuses on medical practitioners (Dywili, Bonner, Anderson, & O'Brien, 2012; Hawthorne, 2013a). The WHO's (2006) projection of a critical shortage of healthcare professionals, including doctors, nurses and midwives in African, Southeast Asian and Mediterranean countries, has proved to be accurate (see Table 1.1) (Blacklock, Ward, Heneghan, & Thompson, 2014; Naicker, Eastwood, Plange-Rhule, & Tutt, 2010). The greatest shortages have occurred in Southeast Asia and sub-Saharan Africa (Blacklock et al., 2014; Cooper & Kirton, 2013; Poppe et al., 2014; WHO, 2006) because doctors and nurses are migrating from these regions to work in OECD countries such as Australia. In 2013–2014, 460,000 internationally educated doctors and 570,000 internationally educated nurses were estimated to be working in OECD countries (OECD, 2016).

The shortage of health workers in OECD countries is predicted to reach 4.3 million by 2030, including 2.48 million nurses (see Table 1.2) (Scheffler & Arnold, 2018). In addition, forecasts from the Registered Nurse Forecasting project 2009–2011 indicate that the impending and significant number of nurses who intend to leave the profession will affect the provision of safe nursing care (Zander et al., 2016). While the crisis in health human resources is well documented, the effect on the workforce of host countries is less well known.

Table 1.1. Estimated Critical Shortages of Doctors, Nurses and Midwives by WHO region (WHO, 2006)

WHO Region	Number of countries		In countries with shortages		
	Total	With shortages	Total stock	Estimated shortages	Percentage increase required
Africa	46	36	590,198	817,992	139
Americas	35	5	93,603	37,886	40
Southeast Asia	11	6	2,332,054	1,164,001	50
Europe	52	0	NA	NA	NA
Northern Mediterranean	21	7	312,613	306,031	98
Western Pacific	27	3	27,260	32,500	119
World	**192**	**57**	**3,355,728**	**2,358,470**	**70**

NA, not applicable. Source (WHO, 2006, p.13)

Table 1.2. Nurse Supply and Demand Projection 2030 by OECD Country (Adapted from Scheffler & Arnold, 2018, p. 10)

Country	Demand	Supply	Surplus/shortage	Surplus/shortage (as % of supply
Australia	427,567	299,067	−128,500	−43.0
Austria	101,760	78,790	−22,970	−29.2
Canada	564,304	446,703	−117,601	−26.3
Czech Republic	123,864	86,625	−37,239	−43.0
Denmark	126,084	136,951	+10,867	+7.9
France	838,253	873,940	+35,687	+4.1
Germany	1,426,505	1,452,273	+25,768	+1.8
Hungary	73,663	68,625	−5,039	−7.3
Iceland	7,800	6,793	−1,007	−14.8
Israel	67,856	46,619	−21,237	−45.6
Korea	413,528	385,908	−27,620	−7.2
Luxembourg	9,211	11,867	+2,656	+22.4
Mexico	594,561	495,758	−98,804	−19.9
Netherlands	365,078	260,151	−104,928	−40.3
Poland	383,278	237,304	−145,973	−61.5
Slovakia	57,126	30,218	−26,909	−89.0
Slovenia	26,355	20,977	−5,378	−25.6
Spain	267,875	318,712	+50,837	+16.0
Sweden	151,110	140,702	−10,408	−7.4
Switzerland	245,736	212,657	−33,079	−15.6
Turkey	221,414	305,367	+83,953	+27.5
UK	824,163	727,291	−96,872	−13.3
US	6,093,332	4,286,071	−1,807,261	−42.2
Total (23 countries)	**13,410,421**	**10,929,369**	**−2,481,052**	**−22.7**

The literature provides insights into projected nursing shortages, global nurse migration patterns and the experiences of IQRNs immigrating and working in host country healthcare settings. IQRNs' experiences of migrating to a new country and healthcare system have been acknowledged in the literature; however, there is a dearth of research on the effect of IQRNs integrating into and working with AQRNs in the Australian healthcare system. Further, minimal research has been conducted on AQRNs' experiences working with IQRNs in the Australian healthcare system (Kawi & Xu, 2009; Konno, 2006; Zhou, 2014). There is also limited literature on education and support required by AQRNs to assist the successful transition of IQRNs into practice (Timilsina Bhandari, Xiao, & Belan, 2015; Ohr et al., 2014).

The integration process of IQRNs working in the Australian healthcare system has not been widely investigated (Chun Tie, Birks, & Mills, 2018). Nurse workforce planning requires an understanding of these processes to facilitate the formation of diverse, yet cohesive, positive working environments that enable nurses to better serve populations requiring healthcare services. A positive work environment is influential and crucial to nurse retention, improved safety and quality in nursing care, improved patient outcomes and increased patient satisfaction (Aiken et al., 2012; Bradley et al., 2018). In addition, transitioning into a foreign health service presents challenges to leaders to enable IQRNs to provide culturally competent care within different models of healthcare systems and diverse populations (Dauvrin & Lorant, 2015). Understanding the process of integration and adaption for AQRNs and IQRNs working together in the Australian healthcare system will assist nurse leaders, educators and policymakers to better understand the factors that contribute to safe practice and inform the development of strategies for the successful integration of IQRNs into the Australian healthcare workforce.

Therefore, to undertake this research study, the methodology selected must be appropriate to answer the research question to determine the processes used by nurses to work together. The research question determines the selection of a methodology to best answer the research question posed. I wanted to understand the processes used by RNs and develop a theory that explained these processes; therefore, grounded theory (GT) was selected as an appropriate methodology. GTM and the application of GT methods in this study will be discussed in Chapter 3 and Chapter 4.

1.5 Research aim

The aims of this study are to explore how IQRNs and AQRNs adapt to working together in the Australian healthcare system and develop a theory that explains this process.

1.6 Research question

What is the process by which IQRNs are integrated into the Australian healthcare system?

1.7 Research design

GT is the methodology employed in this research. This methodology is appropriate when the research seeks to investigate a human process. GT is an inductive methodology that develops theory from the data when the outcomes are not predictable at the commencement of the research. The emphasis on theory development differentiates GT from other qualitative methods (Strauss & Corbin, 1994).

The emphasis in GT is on data analysis, whereby early data analysis informs future data collection (Charmaz, 2012). In GT, data are systematically gathered and analysed concurrently using essential GT methods. The process is iterative and recursive; therefore, GT lends itself to openness to empirical leads that would otherwise be overlooked, allowing the researcher to pursue emergent questions. As an inductive methodology, participant recruitment is guided by the data analysis and theoretical sampling of the data.

GT is an appropriate approach when little is known about the substantive area of inquiry, when a conceptual theory is required and when the research reveals a process intrinsic to the area being examined (Birks & Mills, 2011; Bryant & Charmaz, 2007; Ralph, Birks, Chapman, & Cross, 2014). The substantive area of inquiry in this study is concerned with the little-known process of integration of IQRNs into the Australian healthcare system. As migration increases and globalisation of the nurse workforce escalates worldwide, it is imperative to understand and explain this process to guide policy and future nurse workforce planning. GT was selected as the theoretical framework to underpin this study because it is a suitable methodology to explain the process of integration and deliver an explanatory theory in the substantive area.

This thesis includes boxed extracts from procedural and analytic memos that were written throughout the research study. These extracts will provide context, additional clarity and further insights into the research processes undertaken in this study. In addition, boxed excerpts and exemplars from other contextual data are included to further inform the reader.

1.8 Structure of the thesis

Chapter 1 Introduction: This chapter provides an overview of the impetus and significance of the research study. It also presents the aim, research question and methodology selected to answer the research question. The importance of demonstrating congruence between the philosophical position of the researcher and the GTM is introduced through philosophical inquiry.

Chapter 2 Background: This chapter presents the background of the study and positions it in the broader context of the Australian healthcare system and the registration requirements for international nurses in Australia. The chapter includes a journal article published by the researcher on the results of an integrated literature review conducted for this study. The article is titled 'The experiences of internationally qualified registered nurses working in the Australian healthcare system: An integrative literature review'.

Chapter 3 Methodology: This chapter establishes the philosophical position of the researcher. GT is introduced as the methodological design of this study and symbolic interactionism as the lens the researcher used to apply GT methods. The premises of symbolic interactionism are introduced as the lens through which the researcher constructs meaning from people's actions and the processes they use. A broad overview of GT history is presented alongside the research design that underpins this study, and the essential GT methods are defined. A manuscript titled 'Grounded theory research: A design framework for novice researchers' was published in a peer-reviewed journal at the time of the thesis submission and is included in this chapter.

Chapter 4 Methods: This chapter provides details of the GT methods used in the conduct of this study, as well as their application. Data were collected and/or generated and concurrently analysed. Online survey responses and individual interview transcripts were analysed in

addition to memos and field notes. Several focus groups were subsequently conducted with IQRNs and AQRNs to validate the theory.

Chapter 5 Findings: This chapter presents the key findings of this study using the analytic technique of storyline, which is used in GT to explicate the theory grounded in the data. The theory *playing the game* comprises the key findings constructed from the analysis of the data. The chapter includes a manuscript titled 'Playing the game: A grounded theory of the integration of international nurses', which contains a diagrammatic representation of the GT. The manuscript was submitted to a peer-reviewed journal and was 'in press' at the time of the thesis submission.

Chapter 6 Discussion: This chapter discusses the theory of 'playing the game: a GT of the integration of international nurses in the Australian healthcare system' in the context of existing knowledge. It also describes the relevance and contribution of the GT.

Chapter 7 Conclusion: This chapter concludes the study and presents an evaluation of the theory, recommendations and suggestions for further research. Strengths and limitations of the study are also acknowledged.

1.9 Chapter summary

This chapter presented an overview of the impetus for the study and its significance to the nursing workforce. The researcher demonstrated how their philosophical position aligns with the research methodology that aims to answer the research question. The structure of the thesis outline includes manuscripts that have been published, or that are in press, at the time of the thesis submission. An overview of the Australian healthcare system and the regulatory requirements to work in Australia as an RN are presented in the next chapter to add context to the study.

Chapter 2: Background

Chapter 2 introduces the study context by discussing the complexities within the Australian healthcare system and the composition of the Australian health workforce. Nurses, medical practitioners and allied health (AH) professionals form the largest sector of the health workforce. Registration requirements for health professionals in Australia are rigorous, and regulatory and accreditation schemes are in place to protect the public. International nurses migrating to Australia increasingly come from linguistically and ethnically diverse countries. Their qualifications are assessed by the NMBA to ensure that standards and qualification criteria are met. Qualification criteria and pathways to employment for international nurses are tabled in the following sections. To conclude, an integrative literature review undertaken to examine the experiences of IQRNs in the Australian healthcare system is presented as a published article.

2.1 Health systems

The key aim of a health system is to improve health. The WHO states that 'a health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health' (WHO, 2007, p. 2). A health system includes 'efforts to influence determinants of health as well as more direct health-improving activities' (WHO, 2007, p. 2). However, health systems deal with many challenges and need to be responsive to changes in illness presentations, epidemics, population growth, ageing populations, migration and national differences in government policy (WHO, 2007, 2018b). The WHO states that the provision of efficient and equitable services requires resources, financing and stewardship (WHO, 2000, 2016b).

2.1.1 WHO health system framework

The WHO's health system framework depicted in Figure 2.1 captures the functions deemed necessary to develop health workforces and provide services, medical products, vaccines, technologies, fiscal support, and leadership and governance to improve health outcomes (WHO, 2007, 2018a).

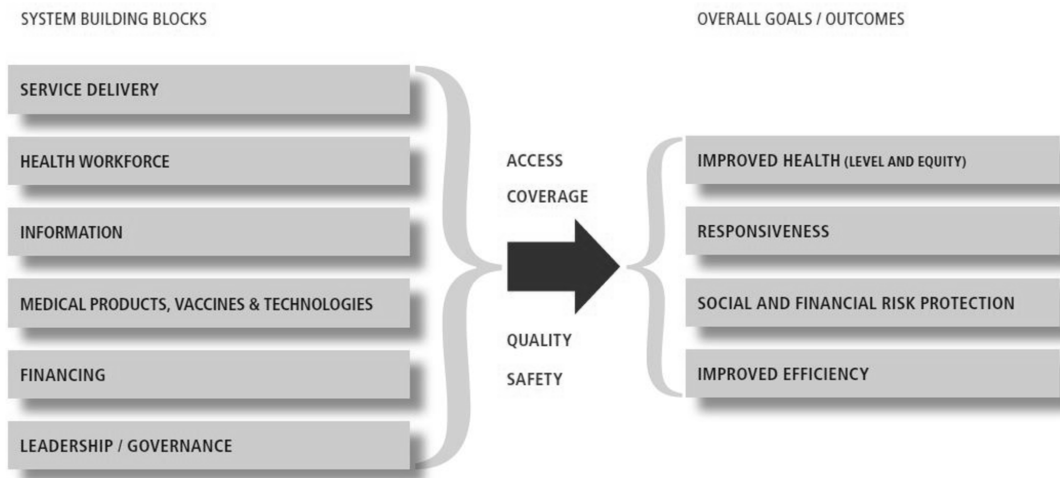

Figure 2.1. Six building blocks of a health system: aims and desirable attributes (WHO, 2007, p. 3)

The WHO's health system framework serves the following function (WHO, 2007, p. iv):

> The building blocks serve three purposes. First, they allow a definition of desirable attributes—what a health system should have the capacity to do in terms of, for example, health financing. Second, they provide one way of defining WHO's priorities. Third, by setting out the entirety of the health systems agenda, they provide a means for identifying gaps in WHO support.

Health systems globally are designed to meet the needs of individual communities and nations. Health systems range from modest systems in developing countries to complex and sophisticated health systems in developed countries such as Australia. Nurses migrate to work in other countries, often moving from less developed or low-income countries to developed or high-income countries such as the UK, US, Canada and Australia (Cometto, Tulenko, Muula, & Krech, 2013; Scheffler & Arnold, 2018).

2.1.2 Human health resource distribution

Nurse migration is a global affair. Nurses migrate for many diverse and complex reasons. Motivations to migrate across international borders include career development and advancement, improved quality of life, increased job satisfaction, to broaden experiences through travel and to leave areas of conflict or war (International Centre on Nurse Migration [ICNM], 2015; Wytenbroek, 2017). Figure 2.2 shows global human health resource distribution in 2006 in terms of workforce population ratios by country. Countries with the greatest need

for healthcare workers are seeing an exodus of nurses from less-developed countries to developed countries such as Australia. The education of nurses who migrate upon graduation from some Southeast Asian countries, including India and the Philippines, has resulted in a continuing pattern of nurses moving from less-developed countries to work in developed countries. The scale of migration has resulted in a billion-dollar global economy in which international nurses from less-developed countries work in developed countries and send money back to their families (Heller, 2015; Kingma, 2008). The source countries of remittances sent home by internationally qualified nurses and other healthcare professionals benefit those countries both financially and in terms of increased skills acquired when those health professionals return to the country from which they migrated (Buchan, Glinos, & Wisma, 2014). Migration is not new; however, the demographics of the countries from which nurses are travelling are changing. There has been an increase in nurses migrating from CaLD countries such as India, the Philippines, China and Zimbabwe to work in Australia over the past two decades.

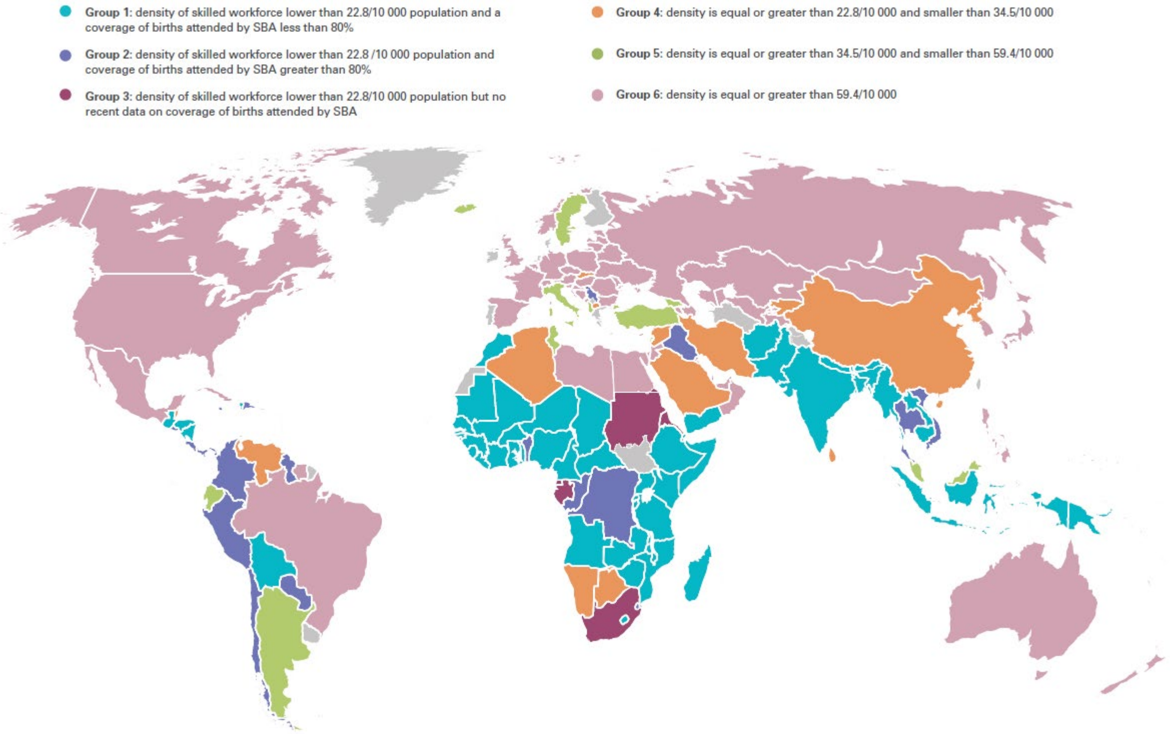

Figure 2.2. Workforce population ratios by country (adapted from WHO, 2013, p. 19)

The ICN recognises the right of nurses to migrate and be free to work where they choose (ICN, 2010, 2018; WHO, 2010). This follows from criticism that developed countries are recruiting or accepting nurses from countries that have an inadequate number of nurses to meet the

needs of their communities, thereby depleting their nursing workforce. In 2010, Bruyneel, Aiken, Lesaffre, Van den Heede and Sermeus (2014, p. 262) stated:

> the World Health Assembly adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel (World Health Organization, 2010). The ambition of this first Code, global in scope, is for WHO Member States to refrain from the active recruitment of health personnel from developing countries facing critical shortages of health workers. The Code also emphasizes the importance of equal treatment for migrant health workers and the domestically trained health workforce.

Australia is a signatory to the ethical recruitment of international nurses (WHO, 2014).

2.2 Australian healthcare system

The Australian healthcare system consists of a number of complex healthcare systems including public, private, public–private partnerships, not for profit, Indigenous services and schemes for those with a chronic illness or disability, such as the National Disability Insurance Scheme (NDIS), which was introduced in 2013 (NDIS, 2017). Australia's healthcare system is not static; systems evolve to meet changing demands for health services, including increases in efficiency and effectiveness measures, management of risk and emphasis on quality and patient satisfaction in healthcare delivery. Australia's regulatory authorities are guided by government policy and regulations and informed by legislation, effectively censoring who can practice as a health practitioner in Australia (NMBA, 2017). RNs who received their education qualification to practice as an RN in a country other than Australia or New Zealand are assessed by the NMBA before being eligible to practice as an RN in Australia. This process is designed to protect the Australian public and the RN.

2.3 Regulation of health professions

The Australian Government regulates health professions in two main ways. First, the Australian Nursing and Midwifery Accreditation Council (ANMAC) is responsible for the accreditation of courses in institutions that educate nurses and midwives (e.g., universities and other higher education providers) to ensure they receive a high-quality education. Second, all health professionals must be registered with a national board under the AHPRA.

Nurses and midwives are registered with the NMBA. Internationally qualified nurses are required to undergo a rigorous assessment before being considered eligible for registration.

2.3.1 Australian Health Practitioner Regulation Agency

The *Health Practitioner Regulation National Law Act 2009* commenced in Australia on 1 July 2010 and was established as a national registration and accreditation scheme with the main aim of protecting the health and safety of the public (AHPRA, 2018b). Before the scheme was introduced, each state had its own regulatory authority. Australia is geographically vast, and the introduction of the scheme simplified workforce movements across six states and two territories by reducing the administrative requirements to be registered in more than one jurisdiction. The national scheme regulates health practitioners and the registration of undergraduate students undertaking a program of study resulting in a qualification that makes them eligible to apply for registration to practice as a health professional in Australia. The scheme is designed to ensure that only suitably qualified health practitioners who are deemed competent to practice in an ethical manner receive registration (AHPRA, 2018b). International health professionals must also meet strict requirements relating to suitable nursing qualification, English-language competency, practice history and criminal history checks before being assessed as eligible to apply for registration to work in Australia (NMBA, 2018c).

A primary function of ANMAC is to ensure that education providers of nursing courses and programs meet the goal of producing graduates with the knowledge, skills, attitudes and behaviours that enable them to build competencies to practice safely and effectively as outlined in the National Competency Standards for the Registered Nurse (ANMAC, 2012). Graduates must satisfactorily complete an accredited program of study before being eligible to register with the NMBA. This includes international nurses aiming to work as RNs in Australia.

2.3.2 Nursing and Midwifery Board of Australia

The NMBA regulates the practice of nursing (and midwifery) to protect the public by ensuring that nurses are competent to practice. It does this by formulating and developing standards, codes of conduct, practices and guidelines that collectively establish requirements for the professional and safe practice of nurses and midwives in Australia (NMBA, 2018a). The code

of conduct for nurses is informed by research, consultation and the profession. The NMBA (2018a, p. 2) states:

> The *Code of conduct for nurses* (the code) sets out the legal requirements, professional behaviour and conduct expectations for nurses in all practice settings, in Australia. The code is written in recognition that nursing practice is not restricted to the provision of direct clinical care. Nursing practice settings extend to working in a non-clinical relationship with clients, working in management, leadership, governance, administration, education, research, advisory, regulatory, policy development roles or other roles that impact on safe, effective delivery of services in the profession and/or use of the nurse's professional skills. The code is supported by the NMBA Standards for practice and, with the other NMBA standards, codes and guidelines, underpins the requirements and delivery of safe, kind and compassionate nursing practice.

The code of conduct for nurses in Australia was updated effective 1 March 2018. The seven principles and values connected to each of the four domains in the code of conduct are outlined in Table 2.1.

The NMBA manages the assessment of internationally educated nurses' knowledge and skills to determine their suitability for registration in Australia under the National Law (NMBA, 2017). Further, it provides information to international nurses planning to work in Australia and explains the difference between ANMAC (immigration) and NMBA (registration) assessments. The NMBA (2018c) states that the:

> ANMAC takes into consideration work experience in assessing an applicant's qualifications, which is then used to determine suitability for skilled migration. Under the National Law, the NMBA can only take into account an applicant's qualifications when establishing whether their qualifications are substantially equivalent to an Australian qualification. This is why some applicants may be approved for skilled migration but do not meet the registration requirements of the NMBA.

Table 2.1. NMBA Code of Conduct for Nurses: Domains, Principles and Values (Effective 1 March 2018)

Domain	Principles and values	
Practice legally	**Principle 1. Legal compliance** **Value**: Nurses respect and adhere to their professional obligations under the National Law and abide by relevant laws.	1.1 Obligation 1.2 Lawful behaviour 1.3 Mandatory reporting
Practice safely, effectively and collaboratively	**Principle 2. Person-centred practice** **Value**: Nurses provide safe, person-centred and evidence-based practice for the health and wellbeing of people and, in partnership with the person, promote shared decision-making and care delivery between the person, nominated partners, family, friends and health professionals. **Principle 3. Cultural practice and respectful relationships** **Value**: Nurses engage with people as individuals in a culturally safe and respectful way, foster open and honest professional relationships and adhere to their obligations about privacy and confidentiality.	2.1 Nursing practice 2.2 Decision-making 2.3 Informed consent 2.4 Adverse events and open disclosure 3.1 Aboriginal and/or Torres Strait Islander people's health 3.2 Culturally safe and respectful practice 3.3 Effective communication 3.4 Bullying and harassment 3.5 Confidentiality and privacy 3.6 End-of-life care
Act with professional integrity	**Principle 4. Professional behaviour** **Value**: Nurses embody integrity, honesty, respect and compassion. **Principle 5. Teaching, supervising and assessing** **Value**: Nurses commit to teaching, supervising and assessing students and other nurses to develop the nursing workforce across all contexts of practice. **Principle 6. Research in health** **Value**: Nurses recognise the vital role of research to inform quality healthcare and policy development, conduct research ethically and support the decision-making of people who participate in research.	4.1 Professional boundaries 4.2 Advertising and professional representation 4.3 Legal, insurance and other assessments 4.4 Conflicts of interest 4.5 Financial arrangements and gifts 5.1 Teaching and supervising 5.2 Assessing colleagues and students 6.1 Rights and responsibilities
Promote health and wellbeing	**Principle 7. Health and wellbeing** **Value**: Nurses promote health and wellbeing for people and their families, colleagues, the broader community and themselves and in a way that addresses health inequality.	7.1 Your and your colleagues' health 7.2 Health advocacy

The code is designed to guide the provision of safe, quality care, yet IQRNs who have been successful in gaining registration to practice as RNs in Australia strive to align their professional identity and the RN role and meet expectations of clinical practice in Australia. Evidence suggests that expectations of practice before arriving in Australia differ from the reality of clinical practice in the Australian context (Brunero, Smith, & Bates, 2008). Therefore, a greater understanding of the needs of international nurses transitioning into a foreign healthcare service is required.

2.3.3 Australian Nursing and Midwifery Accreditation Council

The ANMAC is an external accreditation authority that commenced operations on 1 July 2010 under National Law Section 44 (ANMAC, 2012). Higher education providers of nursing education must meet the requirements of the Registered Nurse Accreditation Standards outlined in Figure 2.3. These standards are used to assess and accredit RNs' programs of study.

STANDARD 1: GOVERNANCE

The education provider has established governance arrangements for the nursing program of study that develop and deliver a sustainable, high-quality education experience for students, to enable them to meet the National Competency Standards for the Registered Nurse.

STANDARD 2: CURRICULUM CONCEPTUAL FRAMEWORK

The program provider makes explicit, and uses a contemporary conceptual framework for the nursing program of study that encompasses the educational philosophy underpinning design and delivery and the philosophical approach to professional nursing practice.

STANDARD 3: PROGRAM DEVELOPMENT AND STRUCTURE

The program of study is developed in collaboration with key stakeholders reflecting contemporary trends in nursing and education; complying in length and structure and complies with the Australian Qualifications Framework (AQF) for the qualification offered and enabling graduates to meet the National Competency Standards for the Registered Nurse. Workplace experience is sufficient to enable safe and competent nursing practice by program completion.

STANDARD 4: PROGRAM CONTENT

The program content delivered by the program provider comprehensively addresses the National Competency Standards for the Registered Nurse and incorporates Australian and international best practice perspectives on nursing as well as existing and emerging national and regional health priorities.

STANDARD 5: STUDENT ASSESSMENT

The curriculum incorporates various approaches to assessment that suit the nature of the learning experience and robustly measure achievement of required learning outcomes, including a summative assessment of student performance against the current National Competency Standards for the Registered Nurse.

STANDARD 6: STUDENTS

The program provider's approach to attracting, enrolling, supporting and assessing students is underpinned by values of transparency, authenticity, equal opportunity and an appreciation of social and cultural diversity.

STANDARD 7: RESOURCES

The program provider has adequate facilities, equipment and teaching resources, as well as staff who are qualified, capable and sufficient in number, to enable students to attain the current National Competency Standards for the Registered Nurse.

STANDARD 8: MANAGEMENT OF WORKPLACE EXPERIENCE

The program provider ensures that every student is given a variety of supervised workplace experiences conducted in environments providing suitable opportunities and conditions for students to attain the current National Competency Standards for the Registered Nurse.

STANDARD 9: QUALITY IMPROVEMENT AND RISK MANAGEMENT

The program provider is able to assess and address risks to the program, its outcomes and students, and has a primary focus on continually improving the quality of the teaching and learning experience for students and the competence of graduates.

Figure 2.3. Registered Nurse Accreditation Standards

2.4 Australian health professions

In 2014, there were 610,148 health practitioners in Australia registered by the relevant national board (see Table 2.2). Nurses and midwives represent the largest sector (57.8% of the health workforce), followed by medical practitioners (16.2%), psychologists (5.16%), pharmacists (4.71%), physiotherapists (4.43%), dentistry (3.26%), occupational therapists (2.75%) and medical radiation practitioners (2.71%). Chiropractors, optometrists, Chinese medicine practitioners, podiatrists, osteopaths, and Aboriginal and Torres Strait Islander health practitioners make up the balance of the registered health workforce (<1% each).

Table 2.2. Number of Health Practitioners Registered in Australia (2014) by Each Respective Board (AIHW, 2016a)

National Boards in Australia responsible for registering health practitioners for their profession	Registered health practitioners	Number registered	~Percentage of workforce
Nursing and Midwifery Board of Australia	Nurses and midwives	352,838	57.83
Medical Board of Australia	Medical practitioners	98,807	16.19
Psychology Board of Australia	Psychologists	31,489	5.16
Pharmacy Board of Australia	Pharmacists	28,751	4.71
Physiotherapy Board of Australia	Physiotherapists	27,011	4.43
Dental Board of Australia	Dentists	15,764	2.58 (total dental = 3.26)
	Dental hygienists	1,645	0.27
	Dental prosthetists	1,223	0.20
	Dental therapists	1,223	0.20
	Oral health therapists	1,120	0.18
Occupational Therapy Board of Australia	Occupational therapists	16,757	2.75
Medical Radiation Practice Board of Australia	Medical radiation practitioners	14,680	2.41
Chiropractic Board of Australia	Chiropractors	4,902	0.80
Optometry Board of Australia	Optometrists	4,855	0.80
Chinese Medicine Board of Australia	Chinese medicine practitioners	4,313	0.71
Podiatry Board of Australia	Podiatrists	4,316	0.71
Osteopathy Board of Australia	Osteopaths	1,968	0.32
Aboriginal and Torres Strait Islander Health Practice Board of Australia	Aboriginal and Torres Strait Islander health practitioners	322	0.05
	Multiple profession registrations	–1,836	0.30
	Total persons registered	**610,148**	

2.5 Registration requirements

Nurse migration occurs worldwide, and nurses migrating to foreign countries usually need to meet the immigration, regulatory and registering requirements of that country before being eligible to migrate and be eligible to practice as a nurse. In Australia, international nurses must meet the NMBA registration standards and the qualification criteria to be eligible for registration (see Table 2.3).

Table 2.3. NMBA Qualification Criteria for IQRNs (October 2018) (NMBA, 2019a).

Criterion	Criterion requirements
1	Your qualification was recognised by a statutory registration/licensing body for registration as a registered nurse or midwife or enrolled nurse in the country your qualification was received and you have met any pre-registration examination requirements. Where there is only one level of nurse in your country your qualification will be assessed at the registered nurse level.
2	At the time you received your qualification as a registered nurse or midwife or enrolled nurse the qualification was subject to quality assurance and recognised or accredited by a body external to the education institution and based on published accreditation standards. The accreditation standards for registered nurse or midwife or enrolled nurse education must include all of the following: • contemporary approaches to education • institutional resources (staffing and facilities) • evidenced based and contemporary nursing and/or midwifery practice • workplace experience across a variety of healthcare settings • medication management that addresses safe and effective use of medicines. The published processes for reviewing programs/providers against the accreditation standards must include all of the following: • an assessment conducted by an individual or team with appropriate expertise in education and in the registered nurse or midwife or enrolled nurse practice • institutional resources (staffing and facilities) • regular review of the program of study such as annual reporting or cyclic re-accreditation.
3	The academic level of your qualification is comparable to, at a minimum, an Australian Bachelor Degree at level 7 (registered nurse or midwife) or Australian Diploma level 5 (enrolled nurse) of the Australian Qualifications Framework.

The AHPRA reviews and assesses applications on behalf of the NMBA. Assessing applications for registration to practice as an RN in Australia involves five stages:

Stage 1: Lodgement of application

Stage 2: Review of qualifications by the AHPRA

Stage 3: NMBA's decision

Stage 4: Communicating the outcome

Stage 5: Appealing a final decision.

The NMBA's recommended pathway to employment in Australia for internationally qualified nurses is presented in Figure 2.4.

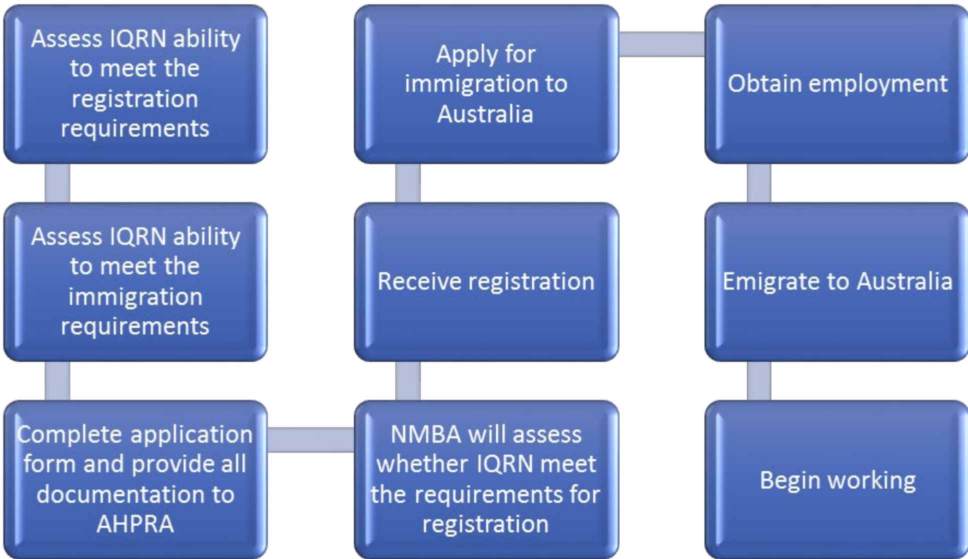

Figure 2.4. NMBA's Recommended Pathway to Employment in Australia for Internationally Qualified Nurses (NMBA, 2019b)

2.6 Qualifications

In 2016, nearly 30% of the Australian RN workforce received their first nursing qualification in a country other than Australia (Department of Health, 2017). Nursing qualifications received in the countries listed in Table 2.4 are assessed to determine whether they meet the qualification criteria outlined in Table 2.3. The NMBA determines which countries may meet the requirements related to Criterion 2 and Criterion 3 because some programs comply with external revue processes while others do not. This means that qualifications are assessed according to whether they meet Criterion 2 and Criterion 3 for the external review of nursing programs rather than the country of origin of the nursing qualification. If a country does not meet the requirements for Criterion 2 or Criterion 3, it is because the education institutions and nursing/midwifery education programs are not subject to systems of regular external review (see Table 2.4).

Table 2.4. Country of Nursing Qualification and Requirements for Qualification Criterion

Australian qualification criterion	Country of completed nursing qualification
Countries likely to meet requirements for Criterion 2 and Criterion 3	Canada, Hong Kong, Republic of Ireland, UK, US
Qualification may meet requirements for Criterion 2 and Criterion 3	Belgium (Flanders Region), Chile, Pakistan, Papua New Guinea, Singapore
Qualification unlikely to meet qualification criteria	Albania, Austria, Bahrain, Bangladesh, Barbados, Belgium (Walloon Region), Bosnia, Botswana, Brazil, Bulgaria, Cambodia, China, Colombia, Cyprus, Denmark, Estonia, Fiji, Former Yugoslav Republic of Macedonia, France, Germany, Ghana, Greece, India, Iran, Iraq, Israel. Italy, Japan, Jordan, Kenya, Lebanon, Lithuania, Malaysia, Malta, Namibia, Nepal, Netherlands, Nigeria, Norway, Oman, Palestinian Territory (Occupied), Philippines, Poland, Portugal, Romania, Russia, Saudi Arabia, Serbia, Slovenia, South Africa, South Korea, Spain, Sri Lanka, Swaziland, Switzerland, Sweden, Taiwan, Thailand, Turkey, Ukraine, Zambia, Zimbabwe

Country of initial nursing qualification was not collected for employed nurses by the AIHW until 2013 (AIHW, 2014). The AIHW's (2014) report identified the 20 leading countries from which international nurses received their first nursing qualification (see Table 2.5).

Table 2.5. Employed Nurses and Midwives: Country of First Nursing/Midwifery Qualification, Selected Characteristics 2014 (AIHW, 2014)

Country of initial nursing qualification	No.	Average age (years)	Aged 50 and over (%)	Female (%)	Average weekly hours worked
Australia	238,464	44.6	40.4	89.9	33.3
New Zealand	7,249	47.5	49.9	90.8	35.1
England	14,699	48.7	47.8	85.8	34.3
Scotland	2,274	46.3	42	86.2	34.4
Ireland	2,283	40.7	33	93.1	34.7
Other Europe	1,601	47.5	43.3	87.6	33.2
Malaysia	210	54.9	71	97.6	34
Philippines	5,878	41.1	20.8	79	37.5
China	1,285	42	22.4	98.1	34.7
India	7,956	36	5.6	85.1	37.1
Sri Lanka	84	48	35.7	86.9	35.8
Middle East	142	45.8	36.6	78.2	33.2
Other Asia	1,281	44.1	31.6	93.1	33.7
Canada	615	45.2	42.3	92.4	32.4
US	623	44.6	39	87	33.3
South America	89	49.1	51.7	96.6	35.1
South Africa	2,082	49.3	46.9	97.2	35.7
Zimbabwe	1,330	42.7	20.4	82.1	39.8
Other Africa	240	44.2	28.8	82.5	39.6
Oceania	43	47	41.9	88.4	35.8
Other	2,463	47.1	43.9	91.9	35.1
Completed midwife survey	1,314	46.6	44.5	77.1	34.7
Not stated	8,774	42	33.2	91.6	32.8
Total	**300,979**	**44.5**	**39.4**	**89.4**	**33.6**

Nurses from India had the lowest average age (36) and worked almost full-time equivalent hours (37.1 hours per week). In 2018, speakers at the National Nursing Forum (NNF) on Australia's Gold Coast indicated that the average nurse in Australia in 2050 will be aged in their mid-thirties and will be from India (NNF, 2018).

International nurses who do not meet the requirements for registration may be directed to undertake further nursing education at an approved Australian higher education provider or successfully complete an approved transition or bridging program for international nurses (AHPRA, 2018a) (see Appendix A).

2.7 Integrated literature review

The following publication reports the findings of an integrative literature review conducted to explore the experiences of IQRNs working in the Australian healthcare system.

The Experiences of Internationally Qualified Registered Nurses Working in the Australian Healthcare System: An Integrative Literature Review

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Professor Melanie Birks

Professor Jane Mills

Submitted to: Journal of Transcultural Nursing

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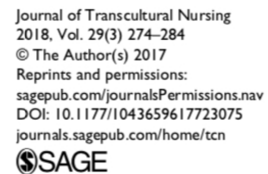

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Abstract

Introduction: International nurses account for 20% of the Australian nurse workforce. This review aims to identify and appraise research findings on the experiences of internationally qualified registered nurses working in the Australian healthcare system. **Methodology:** The review was structured using Whittemore and Knafl modified framework for integrated reviews. A systematic database search was undertaken. Articles (n = 48) were identified for appraisal based on set inclusion and exclusion criteria. Evaluation using the Critical Appraisal Skills Program tool resulted in (n = 16) articles in the final data set. **Results:** Three broad themes were identified: (a) *Transitioning*—Need for appropriate, timely, and adequate supports to assist transition to practice; (b) *Practicing within local contexts*—How expectations were different to the reality of clinical practice; and (c) *Experiencing prejudice*—when racial prejudice occurred. **Discussion:** Appropriate programs including cultural-safety education can mitigate adverse workforce dynamics within culturally diverse health care teams to enable provision of culturally congruent health care.

Keywords

Australia, health care system, internationally qualified, registered nurse

Introduction

In 2015-2016, there were 657,621 registered health practitioners in Australia. Nurses and midwives represented the largest sector at 57.8% of the health workforce (Australian Health Practitioner Regulation Agency, 2016). There is currently an increase in demand in Australia's health labor market due to "Australia's ageing population" and the "implementation of the National Disability Insurance Scheme (NDIS)" (Department of Employment, 2016, p. 2). In 2017, there were 492 community nursing care groups approved by the NDIS to provide care to individuals registered with the scheme with high-care needs (NDIS, 2017). Internationally qualified registered nurses (IQRNs) have been recruited to fill nurse workforce shortages in Australia and make up approximately 20% of the registered nurse (RN) workforce (Australian Institute of Health and Welfare, 2014).

The provision of health care to meet the needs of individuals and communities is complex. Health system resources include the workforce, infrastructure, medical technologies, and access to medicines. Contemporary global issues include the impact of disease, health needs in low-resource settings, vulnerable populations, environmental health issues, sustainable workforces, and complicated matters in areas of conflict (Breakey, Corless, Meedzan, & Nicholas, 2015). Ethical concerns include equitable and just resource allocation, the influence of technological and biotechnological advancements on the provision of care, and respect for diversity in cultures and values (Nicholas & Breakey, 2015). However, one of the most significant challenges for organizations globally, is managing human resources (Tarique & Schuler, 2010).

Projected and actual shortages of nurses and health care professionals affects countries worldwide, including Australia (Health Workforce Australia, 2014). Nursing shortages in many developed countries have resulted in an increase

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in training positions and active recruitment of IQRNs to meet existing and future health workforce demands (Organisation for Economic Co-operation and Development, 2015). In Australia, the nursing skill shortage exists for experienced RNs rather than entry-level new graduates (Australian Institute of Health and Welfare, 2016). Recruitment of IQRNs occurs to meet demand in geographical areas of need, or areas of specialty nursing practice.

Migration of nurses is not new. Key reasons RNs migrate include improved career opportunities, lifestyle, travel, remuneration, or to provide economic support to their families in their country of origin (Newton, Pillay, & Higginbottom, 2012; Ohr, Parker, Jeong, & Joyce, 2010). IQRNs also leave their country of origin to escape civil unrest, war or persecution. Several countries including India, the Philippines, and China educate RNs who plan to migrate to work overseas postgraduation, including to Australia (Walton-Roberts, 2015). However, IQRNs must meet registration requirements to be eligible to practice in Australia (Nursing and Midwifery Board of Australia, 2016).

All health professionals in Australia are required to be registered with the Australian Health Practitioner Regulation Agency (AHPRA). AHPRA was formed in 2010 as the national body to regulate health practitioners in association with the national boards. The national boards are responsible for registering practitioners with the primary purpose to protect the Australian public. Internationally qualified applicants are required to meet the registration standards of their profession, which include the English language skills registration standard and the criminal history registration standard. Depending on the country of origin, additional requirements may need to be addressed by IQRNs seeking to work in Australia (Nursing and Midwifery Board of Australia, 2016).

Demand for health care professionals is expected to increase as population numbers increase, life expectancy continues to rise, rates of chronic disease increase, and the predicted impacts of an aging health workforce prevail (Stankiewicz & O'Connor, 2014). Understanding current recruitment and migration trends of IQRNs to Australia can inform policy directions, resource allocation, and assist with forward workforce planning to enable the successful integration of IQRNs into the Australian healthcare system (AHCS). Therefore, the aim of this integrative review was to identify and appraise research findings about the experiences of IQRNs working in the AHCS.

Method

Whittemore and Knafl (2005) modified integrative review framework was used to structure the review process as illustrated in Table 1. The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) flowchart summarizing the screening process is presented in Figure 1. Data analysis was conducted using the qualitative method of comparative thematic analysis (Richards, 2015).

Electronic databases SCOPUS, CINAHL, and MEDLINE were searched for abstracts and/or full-text articles. The search strategy was formulated and executed systematically for each database using a combination of the following MeSH terms and keywords: registered nurse, nursing staff, foreign professional personnel, international nurse, internationally qualified, overseas educated, foreign trained, qualification, education, trained, workforce, healthcare system, and Australia. Truncation was used to find variations of the same word stem, and phrase searching used inverted commas (" ") to prevent words from being separated. The search terms were used alone and in combination. Boolean terms were used as conjunctions to narrow, broaden, or exclude terms. The use of Boolean terms to combine and/or exclude keywords ensured search results was focused and appropriate. Database searches were retained and saved to allow revision. Reference lists of key articles were hand searched for previously unsourced material to include significant articles that may not have been systematically indexed with MeSH terms in the respective database. Subsequently, three articles were identified for further review. Inclusion criteria were developed and applied to the results to identify articles relevant to the area of inquiry (Table 2). Date limits were selected to reflect articles published after January 1, 2007 in response to the informal dialogue and global cooperation between governments on the effects of international migration (United Nations, 2016).

Methodological rigor of the eligibility of each article was also assessed using the Critical Appraisal Skills

Table 1. Stages in the Review Process Using Whittemore and Knafl (2005) Modified Integrative Review Framework.

Problem identification	Literature search	Data evaluation	Data analysis	Presentation
Area of inquiry: IQRN in AHCS The aim of integrative review is to identify and appraise research findings about the experiences of IQRNs working in the AHCS	Databases: CINAHL, MEDLINE (Ovid), and SCOPUS Key terms Limits: Dates January 1, 2007 to July 1, 2016 Inclusion/exclusion criteria	Records Method CASP tool to appraise relevance, rigor, and quality of the study and then to identify primary records for inclusion	Data extracted from primary sources and coded for key incidents. Comparative analysis of codes conducted and major themes identified.	Major themes

Note. IQRN = internationally qualified registered nurse; AHCS = Australian healthcare system; CASP = Critical Appraisal Skills Programme.

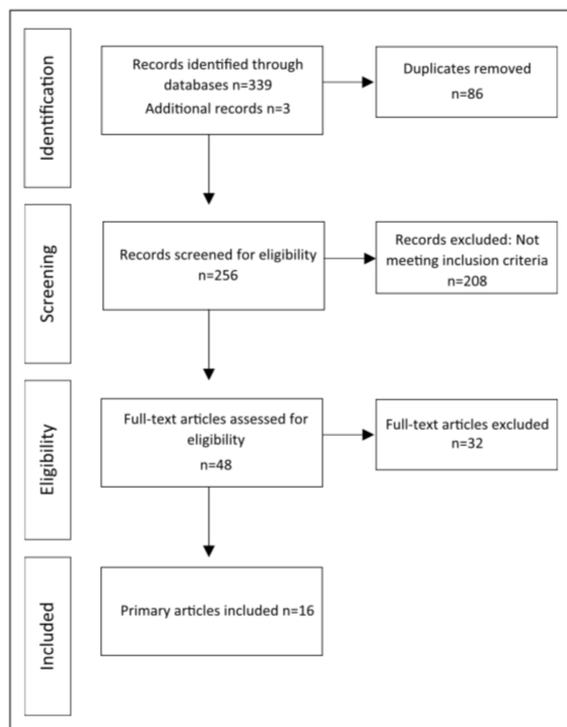

Figure 1. PRISMA flow diagram of search, screening, and selection.
Note. PRISMA = Preferred Reporting Items for Systematic reviews and Meta-Analyses.

Table 2. Inclusion and Exclusion Criteria.

Inclusion criteria	Exclusion criteria
Year range: Published between January 1, 2007 and July 1, 2016	Workshop and conference presentations
Language: Published in English	Working papers
Publication type: Peer-reviewed research articles	Literature—not peer-reviewed research
Setting: Australian healthcare system	Countries other than Australia
Population: Internationally qualified registered nurses	Pre-registration nursing students

Programme (2015) appraisal checklist appropriate for the relevant research design (Whittemore & Knafl, 2005).

A Preferred Reporting Items for Systematic reviews and Meta-Analyses flow diagram was developed that summarizes the selection process used (Figure 1).

Data were analyzed using comparative thematic analysis (Richards, 2015). Data extracted from each article were coded for key incidents. The key research findings in each article were synthesized and summarized using a thematic analysis grid. These results are presented in the following section.

Results

Forty-eight text articles were appraised for methodological rigor, topic relevance, and legitimacy of the findings resulting in a final data set of $n = 16$ articles. Sixteen articles reported on internationally qualified nurses and their experience of working in the AHCS (Table 3). The studies collectively represented participants from over 24 countries including India, China, Philippines, the United Kingdom, Scotland, Holland, Zimbabwe, the United States, Canada, Singapore, Malaysia, Japan, Korea, Nepal, and Africa. Nurses from culturally and linguistically diverse, or a non-English-speaking background (NESB) were cited in most studies. Nurses who migrate to work in another country were referred to as international, overseas trained, immigrant, or overseas-qualified nurses with some studies using several lexes.

Three broad themes were identified from the analysis: Transitioning; Practicing within local contexts; and Experiencing prejudice.

Theme 1: Transitioning

Transitioning refers to the processes IQRNs undertake to integrate into a new health care system. The studies identified that the integration of IQRNs into the AHCS involved complex, multidimensional processes, and players (Jeon & Chenoweth, 2007; Kawi & Xu, 2009; Wellard & Stockhausen, 2010). Organizations and health care institutions are responsible for providing policies and resources to enable IQRNs to transition successfully into the AHCS (Xiao et al., 2014). Key elements for this integration included sufficient organizational support, recognition of expectations by all parties, and comprehensive orientation programs (Dywili et al., 2012). In addition, an organizational approach that values and respects cultural diversity enabled IQRNs to transition successfully into the workforce (Brunero et al., 2008; Dywili et al., 2012).

Organizations and healthcare institutions expect IQRNs complete a transition and/or orientation program, to facilitate enculturation to the AHCS. Studies found programs tailored to meet the needs of individual IQRNs, taking into consideration educational background and previous experiences, were the most useful (Brunero et al., 2008; Jeon & Chenoweth, 2007). The IQRNs themselves expect efficient recruitment processes, an effective orientation, and initial and ongoing mentor support (Dywili et al., 2012) during the transition period. While all nurses found hospital and ward-level orientation programs helpful, IQRNs from a NESB rated the programs more positively (Brunero et al., 2008).

Several studies identified that nurse leaders need resources to facilitate the integration of international nurses into the AHCS (Jeon & Chenoweth, 2007; Xiao et al., 2014). Insufficient supports can compromise workforce integration and affect rapport between the international and local RN (Xiao et al., 2014). This is particularly evident for

Table 3. List of Reviewed Articles and Summary of Results.

	Author (year)	Title/journal	Aim	Methodology/method	Participants/sample/setting	Results/findings (excerpts from articles)
1	Brunero, Smith, and Bates (2008)	Expectations and experiences of recently recruited overseas-qualified nurses (OQNs) in Australia/*Contemporary Nurse*	This study examines the experiences and needs of a group of OQNs at a major metropolitan tertiary referral hospital in Australia	Descriptive survey	*n* = 56 OQNs at a major metropolitan tertiary referral hospital in Australia.	Nurses reported their experiences with three major themes emerging, career and lifestyle opportunities, differences in practice and homesickness.
2	Dywili, Bonner, Anderson, and O' Brien (2012)	Experience of overseas-trained health professionals in rural and remote areas of destination countries: A literature review/*Australian Journal of Rural Health*	This study aimed to review and synthesize existing literature that investigated the experience of overseas-trained health professionals (OTHPs) in rural and remote areas of destination countries.	A systematic literature review using electronic databases and manual search of studies published January 2004 to February 2011. Data were analyzed from articles that met inclusion criteria.	*n* = 17 Articles. The reviewed research studies were conducted in Australia, Canada, New Zealand, the United Kingdom, and the United States. Overseas-trained medical practitioners were the most frequently researched (*n* = 14); two studies involved nurses and one study included several health professionals.	Three main themes emerged from the review and these were the following: (a) expectations, (b) cultural diversity, and (c) orientation and integration to rural and remote health work environment.
3	Francis, Chapman, Doolan, Sellick, and Barnett (2008)	Using overseas registered nurses (RNs) to fill employment gaps in rural health services: Quick fix or sustainable strategy?/*Australian Journal of Rural Health*	Objective: This study sought to identify and evaluate approaches used to attract internationally trained nurses from traditional and nontraditional countries and incentives employed to retain them in small rural hospitals in Gippsland, Victoria.	Design: An exploratory descriptive design.	Setting: Small rural hospitals in Gippsland, Victoria. Participants: Hospital staff responsible for recruitment of nurses and overseas-trained nurses (OTNs) from traditional and nontraditional sources (e.g., England, Scotland, India, Zimbabwe, Holland, Singapore, Malaysia).	Recruitment of married OTNs is more sustainable than that of single RNs; however, the process of recruitment for the hospital and potential employees is costly. Rural hospitality diffuses some of these expenses by the employing hospitals providing emergency accommodation and necessary furnishings. Cultural differences and dissonance regarding practice create barriers for some of the OTNs.
4	Gillespie, Chaboyer, Lingard, and Ball (2012)	Perioperative nurses' perceptions of competence: Implications for migration/*ACORN: Journal of Perioperative Nursing in Australia*	This article describes Canadian and Australian nurses' levels of perceived perioperative competence and discusses these results in the context of nurse migration.	Perioperative competence was measured with a 40-item self-report survey. Nonparametric tests were used to describe differences between groups based on country of origin, years of experience and qualifications.	Nurses in six hospital sites (three in Canada and three in Australia).	Canadian and Australian nurses reported their overall competency levels as high across all domains. Significant differences were found, between countries, in three of the six competency domains; foundational knowledge and skills ($p < .001$), collegiality ($p = .023$), and empathy ($p < .0001$). The increasing global mobility of nurses makes it imperative to further standardize with an international perspective, knowledge, and practice expectations in perioperative settings.
5	Jeon and Chenoweth (2007)	Working with a culturally and linguistically diverse (CALD) group of nurses/*Collegian*	To provide a critical examination of the issues and challenges relating to the employment of OQNs within Australia and international contexts.	Data analysis	OQNs in Australia.	New OQNs experience difficulties with language, communication styles, unfamiliar nursing practice, and work environment as well as cultural difference. Require support to acculturate to unfamiliar work conditions, and make a smooth transition to the health team. Australian trained nurses also need to be supported in terms of being given opportunities to develop cultural competence and to learn how to work collaboratively within the CALD work setting.

(continued)

Table 3. (continued)

	Author (year)	Title/journal	Aim	Methodology/method	Participants/sample/setting	Results/findings (excerpts from articles)
6	Kawi and Xu (2009)	Facilitators and barriers to adjustment of international nurses: An integrative review/*International Nursing Review*	Aim: This integrative review identifies facilitators and barriers encountered by INs as they adjust to foreign health care environments.	Method: Based on Cooper's Five Stages of Integrative Research Review, a systematic search of eight electronic databases was conducted, combined with hand and ancestral searches.	Findings: Twenty-nine studies conducted in Australia, Canada, Iceland, the United Kingdom, and the United States were included in this review. Subsequently, facilitators and barriers were identified and categorized into themes and subthemes	Findings indicated that positive work ethic, persistence, psychosocial, and logistical support, learning to be assertive and continuous learning facilitated the adjustment of INs to their new workplace environments. In contrast, language and communication difficulties, differences in culture-based lifeways, lack of support, inadequate orientation, differences in nursing practice, and inequality were barriers.
7	Kishi, Inoue, Crookes, and Shorten (2014)	A Model of adaptation of overseas nurses: Exploring the experiences of Japanese nurses working in Australia/*Journal of Transcultural Nursing*	The purpose of the study was to investigate the experiences of Japanese nurses and their adaptation to their work environment in Australia.	Qualitative research method, individual semistructured interviews, thematic analysis used to identify themes within the data.	*n* = 14 Japanese RNs working in Australian hospitals	The conceptual model of the adaptation processes of 14 Japanese nurses working in Australia includes the seeking, acclimatizing, and settling phases. Although these phases are not mutually exclusive and the process is not necessarily uniformly linear, all participants in this study passed through this S. A. S. model to adapt to their new environment.
8	Mapedzahama, Rudge, West, and Perron (2012)	Black nurse in white space? Rethinking the in/visibility of race within the Australian nursing workplace/*Nursing Inquiry*	This article presents an analysis of data from a critical qualitative study with 14 skilled Black African migrant nurses experiences of racism and racial prejudice in Australian nursing workplaces.	Essed's framework of "everyday racism" to theorize narratives	*n* = 14 Black African migrant nurses working in Australian nursing workplaces	Racism generally and nurse-to-nurse racism specifically, continues to be underresearched in explorations of these workplaces; when racism is researched, the focus is nurse-to-patient racism and racial prejudice.
9	O'Neill (2011)	From language classroom to clinical context: The role of language and culture in communication for nurses using English as a second language: A thematic analysis/*International Journal of Nursing Studies*	Explores the experiences of internationally educated nurses using English as a second language, recruited by advanced economies to supplement diminishing local workforces, as they progress from language learning programs to clinical settings	Semistructured interviews, nurses' narratives, thematic analysis	*n* = 10 Internationally educated nurses. Participants: Six female participants and four male. Five participants were Indian, four Chinese, and one Nepalese.	Themes of identity and belonging, safety and competence and adapting to new roles and ways of communicating are revealed. In their own words, these nurses reveal the challenges they face as they concurrently manage the roles of language learners and professionals.
10	Smith, Fisher, and Mercer (2011)	Rediscovering nursing: A study of overseas nurses working in Western Australia/*Nursing & Health Sciences*	This article presents the findings of a study, based on Husserlian phenomenology that describes the work experience of 13 female nurses who were working in Western Australia, Australia.	Husserlian phenomenology	*n* = 13 Female nurses who were working in Western Australia	The participants were taken aback by the way that nursing is practiced in Western Australia. The major differences that they encountered were related to clinical skills, holistic care, the work dynamic with doctors and patients, and the overall societal status of the nursing profession. As a result, they had to adjust their practice to conform to the new work environment.
11	Takeno (2010)	Facilitating the transition of Asian nurses to work in Australia/*Journal of Nursing Management*	The purpose of the present study was to explore the perceptions of Korean and Japanese nurses' about nursing in Australia	Qualitative research methodology comprised in-depth semistructured interviews	Five RNs, who had worked in both Australia and their home country of Korea or Japan	Research participants were mostly satisfied with working conditions, support, and continuing nursing education in Australia. English language deficits, differences in culture and beliefs about the nurse's role were found that could create the potential for misunderstandings. Recognized too much help may be a form of covert discrimination.

(continued)

Table 3. (continued)

	Author (year)	Title/journal	Aim	Methodology/method	Participants/sample/setting	Results/findings (excerpts from articles)
12	Timilsina Bhandari, Xiao, and Belan (2015)	Job satisfaction of overseas-qualified nurses working in Australian hospitals/*International Nursing Review*	To explore factors associated with the job satisfaction of OQNs working in South Australia. Compare satisfaction between English-speaking and non-English-speaking background (NESB) OQNs	A cross-sectional survey using the job satisfaction of OQNs questionnaire	*n* = 151 OQNs from 24 countries recruited from five SA hospitals	Four factors influence job satisfaction: Supportive work environment, interpersonal relationships, communication in English, and salary and salary-related benefits. Communication most associated with job satisfaction in nurses from NESB. NESB nurses require support early in their employment, especially with their communication skills. Open-ended questions revealed discrimination and racism issues.
13	Wellard and Stockhausen (2010)	Overseas trained nurses working in regional and rural practice settings: Do we understand the issues?/*Rural and Remote Health*	This review explored the contemporary understandings of the employment of OTNs in Australian regional and rural practice settings.	An integrative literature review was undertaken. A search of electronic databases and relevant web pages was undertaken for the publication period 1995 to 2008.	Following identification of relevant literature, thematic analysis was undertaken to reveal patterns and relationships among concepts facilitating synthesis of findings across the range of literature	This review identified a number of economic and ethical issues, together with risks for potential exploitation of migrant nurses. There was minimal literature specific to the experiences of OTNs working in regional and rural areas. The employment of OTNs is accompanied by complex and varied issues which require resourceful and proactive responses by health care employers. Increased understanding in clinical settings of factors that influence nurses to migrate, as well as the range of barriers they face in working and living in host countries, may assist in the retention of these nurses.
14	Xiao, Willis, and Jeffers (2014)	Factors affecting the integration of immigrant nurses into the nursing workforce: A double hermeneutic study/*International Journal of Nursing Studies*	The aim of this study was to examine interplaying relationships between social structures and nurses' actions that either enabled or inhibited workforce integration in hospital settings.	Giddens' Structuration Theory with double hermeneutic methodology. Face-to-face in-depth interviews and focus groups.	*n* = 24 Immigrant and *n* = 20 senior Australian nurses working in an Australian metropolitan city hospital setting	Four themes identified: (a) employer-sponsored visa as a constraint on adaptation (b) two-way learning and adaptation in multicultural teams (c) unacknowledged experiences and expertise as barriers to integration (d) unquestioned subgroup norms as barriers for group cohesion.
15	Zhou, Windsor, Coyer, and Theobald (2010)	Ambivalence and the experience of China-educated nurses working in Australia/*Nursing Inquiry*	Based on our study findings on the experience of China-educated nurses working in Australia, this study proposes that the concept of ambivalence is more appropriate in portraying the experience of immigrant nurses.	Modified constructivist grounded theory. Symbolic Interactionist approach. In-depth interviews.	*n* = 28 Purposive sample of China educated nurses working >6 months as RN in AHCS in Brisbane and Adelaide	Conflicting social and cultural norm, immigration ambivalence; discrepancies between expectation and reality, Perceptions include dual-reference points of comparison, and divergent interests within families.
16	Zhou, Windsor, Theobald, and Coyer (2011)	The concept of difference and the experience of China-educated nurses working in Australia: A symbolic interactionist exploration/*International Journal of Nursing Studies*	In reporting on an analysis of data drawn from China-educated nurses working in the Australian health care system, this article explores the social construction of difference and the related intersection of difference and racialization.	Symbolic interactionist approach informed in-depth interviews. Analysis was initial and focused coding and constant comparison of data.	*n* = 28 China educated nurses employed as RNs in Australia.	Two levels of meaning were depicted in this study: difference as "you are you and I am I" and difference as "incompetence." Negative meanings were ascribed to difference which in turn legitimized inequality and held the potential to perpetuate racism.

international nurses from a culturally and linguistically diverse or NESB. Australian RNs also require resources to facilitate IQRNs transition to the workplace (Jeon & Chenoweth, 2007). Resources include programs and activities that promote positive intergroup connections and intercultural understanding (Xiao et al., 2014). Enabling welcoming environments, and acknowledging each other's background and experiences, increases both parties' understanding of diversity and strengthens bonds between existing and new staff members (Brunero et al., 2008). These strategies were found to encourage engagement and improve workplace cohesiveness.

The context of health care delivery was identified as an important consideration. Placing IQRNs into unfamiliar environments was recognized as a constraint to effective integration. Studies identified IQRNs need added time to transition and adjust to new or unfamiliar work environments (Wellard & Stockhausen, 2010). Reports suggest it can take up to 2 years for IQRNs "to get on their feet and be useful to the organisation" (Francis et al., 2008, p. 167). Jeon and Chenoweth (2007) also found internationally qualified nurses require additional time to acculturate to unfamiliar work environments and transition to the health care team, and found adjustment related to language and nursing practice can take several years.

While organizations value the increased diversity IQRNs bring to workplaces (Brunero et al., 2008), increased cost related to recruitment and the transition period were identified as a constraint. Studies revealed added costs were incurred by organizations in rural environments. These added costs included providing subsidized housing to attract staff and increased supernumerary hours for IQRNs during orientation (Francis et al., 2008). Hidden costs arose in rural areas when IQRNs employed full-time on temporary skilled work visas either reduced their hours to part-time or left to work in regional or metropolitan areas once the visa period is completed (Francis et al., 2008).

Overall, IQRNs report feeling well supported when communities were welcoming and accepting of cultural diversity as it related to themselves and/or their families. This experience was particularly evident in rural communities (Francis et al., 2008; Wellard & Stockhausen, 2010). The acceptance of cultural diversity within communities highlights the importance of sociocultural connection during IQRNs' transition period (Dywili et al., 2012; Smith et al., 2011). Integration of new staff is evaluated as successful when job satisfaction increases, positive work environments are sustained and staff retention improves (Dywili et al., 2012).

Theme 2: Practicing Within Local Contexts

Conflicting expectations around scope of practice (SoP) dominate the literature, with numerous studies confirming IQRNs expectations of nursing practice were different to the reality of clinical practice in the AHCS (Brunero et al., 2008; Francis et al., 2008; Gillespie et al., 2012; Jeon & Chenoweth, 2007; Kawi & Xu, 2009; Smith et al., 2011; Zhou et al., 2010). Health care institutions expected IQRNs have the clinical competency to provide safe, appropriate, culturally sensitive nursing care (Dywili et al., 2012; Jeon & Chenoweth, 2007). IQRNs expectations include recognition of their skills and previous experiences, appropriate organizational orientation, and ongoing peer support (Dywili et al., 2012). However, studies found IQRNs previous experience was not always recognized or acknowledged meaning IQRNs had to adjust their usual SoP to work in their new environment (Smith et al., 2011). For example, IQRNs were unable to practice their standard nursing skills such as cannulation until they completed a competency assessment (Brunero et al., 2008). Conversely, a growing body of literature identifies that nurses from some East Asian countries are unwilling or confronted by the expectation that they will need to incorporate holistic nursing care into their clinical practice (Francis et al., 2008; Smith et al., 2011). These nurses were unaccustomed to completing patient hygiene measures or feeding patients as, in their home country, the patient's family carry out these tasks. These nurses regarded undertaking these tasks was a belittlement of their professional status as an RN (Smith et al., 2011).

Australia's model of person-centered practice also provided a challenge for many IQRNs (Kawi & Xu, 2009). Collaborative and respectful communication with patients is central to this model of care. The importance of recognizing the cultural differences in therapeutic communication was illustrated in several studies (O'Neill, 2011; Zhou et al., 2011). Hierarchical structures exist in health care systems and are perceived differently in different cultures (Kishi et al., 2014). RNs from China, Japan, or India are accustomed to patients accepting the doctor or senior nurse's instructions without question. Yet in Australia, therapeutic communication is more collective with health professionals and patients collaborating in decision making (Smith et al., 2011).

English language proficiency, understanding Australian colloquialisms, pronunciation, or accents also proved challenging for IQRNs (Jeon & Chenoweth, 2007; O'Neill, 2011). Nonverbal communication was also observed by Kawi and Xu (2009) as causing potential misunderstandings between health professionals and patients. Several studies acknowledged IQRNs experienced additional challenges learning variations in drug names, and in understanding the meaning ascribed to abbreviations in medical and nursing staff communications (Jeon & Chenoweth, 2007; Takeno, 2010). This was also true for native English-speaking nurses (Zhou et al., 2011), which means this is likely reflective of all RNs preparation for this component of practice.

The literature (Kishi et al., 2014; Timilsina Bhandari et al., 2015) recognized that a positive work environment is predictive of improved retention of both international and local nurses. These findings also argue that health care

delivery is shaped and influenced by the context or setting in which it occurs (Smith et al., 2011). While it is widely recognized that English language proficiency and interpersonal relationships are important, positive, and supportive work practice environments influence job satisfaction (Kishi et al., 2014; Timilsina Bhandari et al., 2015). Using narratives of IQRNs' experience to increase understanding of the dominant workplace culture was found to be a useful approach to improve cohesion (Brunero et al., 2008). Other results identified that positive group integration between local and international nurses occurred during informal conversations in relaxed or casual settings (Xiao et al., 2014). Conversely, one study found the local staff was excluded by language and reverse cultural barriers when IQRNs formed subgroups (Xiao et al., 2014).

Studies revealed not all IQRNs had positive experiences transitioning into the health workforce. Inadequate resources, insufficient support or educational information, nonrecognition of skills, knowledge or experience, inequity of opportunity for career advancement, and cultural barriers were identified by IQRNs as constraints to integrating into the AHCS (Dywili et al., 2012; Francis et al., 2008; Jeon & Chenoweth, 2007; Kawi & Xu, 2009; Xiao et al., 2014). Studies also identified IQRNs experienced incongruence between the expectations of the job and the actual demands of the job (Smith et al., 2011) that were compounded by the different values they held resulting in challenges during the transition period. However, Timilsina Bhandari et al. (2015) study found that developing respectful interprofessional relationships with staff, colleagues, and community, in addition to remuneration and being able to communicate proficiently in English, were positively associated with job satisfaction.

Theme 3: Experiencing Prejudice

Racial prejudice expressed in nurse-to-nurse racism, and patient-to-nurse racism occurred within organizations and communities (Mapedzahama et al., 2012; Timilsina Bhandari et al., 2015; Zhou et al., 2011). Yet contemporary racism can manifest itself in subtle forms. For example, experiences of racism and discrimination were inscribed in IQRNs' descriptions of experiencing increased feelings of homesickness, feelings of exclusion, or marginalization. Several studies cite when language and culture are used to classify difference, this can result in stereotyping cultural behaviors (Kawi & Xu, 2009; Mapedzahama et al., 2012; Zhou et al., 2011). Stigma also occurs when negative meanings are ascribed to difference, which can perpetuate racism (Zhou et al., 2011).

IQRN's experience of discrimination was acknowledged in several studies (Takeno, 2010; Timilsina Bhandari et al., 2015; Xiao et al., 2014). These authors' referred to the non-recognition of overseas qualifications, skills, knowledge, or experience as discriminatory (Smith et al., 2011; Timilsina Bhandari et al., 2015). Reports of IQRNs being denied the opportunity to practice in their area of expertise were also identified (Brunero et al., 2008) as discriminatory. Being labelled as *incompetent* or *needs surveillance* was similarly seen by IQRNs as discriminatory. Career advancement or promotion opportunities for NESB nurses were discussed as compromised, limited, or denied (Kawi & Xu, 2009; Timilsina Bhandari et al., 2015). However, when too much assistance was proffered IQRNs also perceived this as a form of covert discrimination (Takeno, 2010). Therefore, organizations and nurse leaders need to comprehend the complexity and social dynamism of workplaces and how this affects an IQRNs transition to working in the AHCS. Being sensitive to the social dynamics of workplaces can provide insight into potential incidences requiring intervention (Mapedzahama et al., 2012).

Several studies identified that nurse managers also require organizational support to manage issues and complaints surrounding racism, discrimination, or prejudicial behavior (Timilsina Bhandari et al., 2015; Xiao et al., 2014). Issues raised by nurses need to be acknowledged and addressed by managers to avoid *passive* racism which occurs when leaders remain silent or do not act to address incidents of discrimination (Mapedzahama et al., 2012). Studies identified management need resources to implement and action anti-racism and anti-discrimination policies, and to advocate for zero tolerance. These studies suggest additional resources such as cultural awareness programs will support nurse managers to address prejudicial behavior in workplace interactions (Smith et al., 2011; Xiao et al., 2014).

Discussion

The reviewed literature identified that orientation programs and supportive strategies are vital in facilitating an individual nurse's successful transition to a foreign health service. However, the efficacy of the existing orientation programs designed to assist transition is yet to be determined in terms of impact (Covell, Neiterman, & Bourgeault, 2016). Much of the discussion in the literature has centered on the need to provide timely and ongoing support during transition, while the most successful programs have emphasized meeting an individual's needs and level of cultural awareness (Kehoe et al., 2016). Therefore, transition programs should be tailored to meet specific needs and incorporate cultural awareness at both the organizational and the individual level. Programs and policy aimed at improving the cultural responsiveness capabilities of nurses and healthcare organizations can improve outcomes for patients and communities while improving IQRNs adeptness to integrate successfully into the work environment.

Within the nursing profession, an understanding of the differences in educational preparation in countries of origin can reduce confusion over the SoP for IQRNs. The Nursing and Midwifery Board of Australia (2016) provide the following definition of SoP for the RN:

> Scope of practice is that in which nurses are educated, competent to perform and permitted by law. The actual scope of practice is influenced by the context in which the nurse practises, the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider.

This review highlights that the expectations of IQRNs often differed from the reality of clinical practice. Few international health professionals consider differences in national practices in advance of their transition into the new workforce (Harris, 2011). These findings suggest mutual discourse needs to occur to clarify the expectations around SoP at the point of care. In addition, a shared understanding of IQRN's education and clinical experience may identify the strengths that IQRNs bring to the workplace and enable these nurses to work to their full potential.

Such understanding is particularly important when ambiguity exists as to how differences in educational preparation affect clinical competencies and critical thinking skills. The model of person-centered practice that can prove challenging for IQRNs creates a similar quandary for other overseas-qualified health professionals. Dahm (2011) acknowledged that, while international medical graduates (IMGs) may be experts in medical knowledge, they may not be familiar with Australia's model of person-centered care (PCC), and may have difficulty adjusting their practice. Yet PCC is a key policy driver for quality and safety. While the fundamentals of PCC derived from the nursing, medical, and health policy literature are similar, various professions have focused on different areas within this model (Kitson, Marshall, Bassett, & Zeitz, 2013). Nevertheless, IQRNs and IMGs are both expected to develop a rapport with patients and communicate collaboratively using a person-centered model of care (McGrath, Henderson, Tamargo, & Holewa, 2012).

English language proficiency and having an effective style of therapeutic communication is required for any international health professionals who does not have English as their first language. Although English language proficiency is a prerequisite for registration in Australia, both IQRNs and IMGs from NESBs may also require language support once registered (McGrath, Henderson, & Holewa, 2013). Excluding those who had studied or spoken English at home or school, IMGs from Middle Eastern countries indicate that communicating in English presented significant challenges for them in the workplace (McGrath et al., 2013). Contrary to expectations, it is not the comprehension and written language skills that present the most challenges, but communicating verbally in English. Nevertheless, international health professionals feel they are well understood by their peers (McGrath et al., 2013). An important issue emerging from these findings is that suboptimal communication in English can have a negative impact on patient satisfaction (Sommer, Macdonald, Bulsara, & Lim, 2012). Failure to address communication issues can leave both international health professionals and patients vulnerable.

In addition to language issues, accents also featured in the literature (McGrath et al., 2013). Patient care outcomes can be negatively affected if there is a miscommunication because of poor clarity of English. Findings suggest miscommunications related to accented English and/or lack of local technical terms remain a barrier to effective two-way therapeutic communication. The finding that understanding Australian colloquialisms was an area of difficulty for IQRNs was reflective of IMGs' experiences (McGrath et al., 2013). Notwithstanding such difficulties, IMGs themselves do not consider that their accents or English language proficiency pose a barrier when interacting with patients (Sommer et al., 2012).

Cultural and linguistic diversity exist within health care professions. Much of the literature reviewed approaches language in the context that native English is the gold standard. IQRNs or IMGs from NESBs are discussed in terms of being a problem or having a deficit that needs addressing; less emphasis is placed on the benefits bilingual or multilingual health care professionals bring to the workplace. Yet when differences in cultural and language backgrounds are embraced, opportunities to develop new perspectives and ways of thinking and to learn from each other in the process arise (Chur-Hansen & Woodward-Kron, 2009). It is in this context that cultural competence and cultural diversity education have the potential to inadvertently reinforce local staff members' stereotypes about IQRNs. Thus, the emphasis on *the other* can create power imbalances by inadvertently suggesting that a group is *tolerated* within a community, rather than being an intrinsic part of it. Fostering inclusive environments that acknowledge and accommodate differences can facilitate successful integration of IQRNs. However, successful programs that address workforce diversity require support and engagement at the organizational, institutional, and ward levels. Yet we need to be mindful to not underestimate the complexity within cultural groups. To promote social inclusiveness, health professionals need to be active in providing counterpoint to the prejudices found within nursing and the broader community (Kymlicka & Banting, 2006).

While Australia is a multicultural society, racial discrimination, and prejudice still occurs. It is incumbent on all of us to address racism and discriminatory actions. An implication of the findings of this review is that to enable the provision of culturally congruent and appropriate PCC, nurses also must support each other while working together in the complex, dynamic workplaces that comprise the AHCS. Further research is needed to better understand how healthcare organizations, nurse leaders and nurses themselves can continue to support equity, value cultural diversity and promote cultural tolerance, respect, and appreciation at every level. Future research into the development of specified cultural diversity standards, indicators, and benchmarks to test the efficacy of cultural responsiveness programs is also recommended. Furthermore research to evaluate the ways in which these programs affect patient care is warranted.

Conclusion

The demand for health services worldwide continues to increase at a rate beyond that expected from population growth alone. Political, economic, social, and cultural factors affect nursing workforce migration and health care delivery worldwide. The findings from this review suggest that these migration patterns create a need for increased understanding of the system-level determinants of successful integration. At a local level, the values and culture of the organization affect the transition and integration experiences of international nurses into a foreign healthcare system. This is important evidence to consider in an era of increasing global complexity; as it is vital, we do not underestimate the impact global migration has on health workforces. Cultural competency continuing professional development to improve nurses' ability to communicate effectively with colleagues and patients from different cultures is essential for the provision of culturally congruent health care. Safe, sustainable, and effective provision of health care to meet the requirements of individuals, families, and communities is the ultimate goal of nursing practice, regardless of the place of origin of the practitioner.

Study Limitations

The exclusion of non-English papers and the imposition of a time frame for the reasons described in this article may have resulted in other relevant material not being included. The small sample size is acknowledged; however, this is representative of the available published work. The findings reported in most studies were acknowledged as non-generalizable, mostly due to small sample size or specific contexts.

Authors' Note

YCT, MB, and JM were responsible for the study conception and design and drafting of the article. They made critical revisions to the article.

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2.8 Chapter conclusion

Health systems require competent, safe practitioners to provide health services. This chapter presented an overview of Australia's healthcare system, the healthcare professionals who form the health workforce, and the regulatory and accreditation bodies that collectively ensure the provision of safe, quality healthcare. The integrated literature review of international nurses' experiences established the need for further research into the process of integration and the adaption of nurses into foreign health services. The next chapter presents the foundational concepts of the research. An overview of GTM is introduced in a manuscript titled 'Grounded Theory Research: A Design Framework for Novice Researchers', which describes and substantiates the research design constructed to conduct this study.

Chapter 3: Methodology

3.1 Introduction

GT is the structured but flexible methodology chosen to underpin the research design of this study. GT is appropriate when little is known about the substantive area of inquiry, when the aim is to produce an explanatory theory and when the study uncovers a process inherent to the substantive area of inquiry (Birks & Mills, 2015; Bryant & Charmaz, 2007). Before selecting a methodology, a review of the major research paradigms should be conducted to ensure the appropriate methodology is selected to answer the research question. This chapter begins with an overview of philosophy and the major research paradigms. The links between paradigms, methodologies and methods are explored. The history of GT and the evolution of genres are introduced to add perspective and advance an understanding of the methodology in the manuscript 'Grounded Theory Research: A Design Framework for Novice Researchers'. GT has seen the emergence of new philosophical perspectives that have influenced the methodological development, which has changed over time. The methods and analytic processes that are deemed essential in GT research are subsequently described in the manuscript in an overview of the GT research process.

3.2 Foundational concepts of research

Research is conducted to advance knowledge, establish facts and reach new conclusions derived from the systematic inquiry and disciplined application of research methods (Polit & Beck, 2012). Before commencing research, a strategy or research design is developed to answer the research question. This research design is underpinned by philosophy, methodology and methods (Creswell, 2013). Philosophy is a set of values and beliefs that include how truth and reality are conceptualised. It is described as the lens through which people view the world. Philosophy is defined as 'a view of the world encompassing the questions and mechanisms for finding answers that inform that view' (Birks, 2014, p. 18). Metaphysics, ethics, politics, science, logic, mathematics, art and law are major philosophical categories. Ontology and epistemology are two intrinsically linked philosophical concepts relevant to research that stem from the branch of philosophy known as metaphysics (Birks, 2014; Birks & Mills, 2015). Researchers need to acknowledge their beliefs about the nature of

the social world (ontology) and the nature of knowledge and how it is acquired (epistemology) (Ormston, Spencer, Barnard, & Snape, 2013). Past experiences influence an individual's worldview and how knowledge is constructed. While the research question determines the methodology, it is the researcher's philosophical position that determines how the methods are employed.

The concept *paradigm* was first proposed by Thomas Kuhn in 1962 (Kuhn, 1996). Paradigms can be described as models, theoretical perspectives or frameworks that embody a shared way of thinking of how people view the world. These worldviews, in turn, shape the way knowledge is explored and interpreted. The theoretical perspective is 'the philosophical stance informing the methodology' (Crotty, 1998, p. 3). It provides a context for the process. Thus, a research paradigm can be defined as a way of viewing 'natural phenomena that encompasses a set of philosophical assumptions and that guide one's approach to inquiry' (Polit & Beck, 2008, p. 761). A paradigm is underpinned by ontology (beliefs about reality), epistemology (relationship between the researcher and what can be known) and methodology (Denzin & Lincoln, 2011). Epistemology is the 'theory of knowledge embedded in the theoretical perspective and thereby in the methodology' (Crotty, 1998, p. 3). The two major research paradigms—quantitative and qualitative, also referred to as positivist and interpretivist—are underpinned by different philosophies.

The positivist (quantitative) paradigm is underpinned by a philosophy that asserts that we can only know what is observable and measurable. In health research, positivists accept that there are universal laws about human and societal behaviours that are deducted from objective observations, measurements and recordings from standardised and statistical analyses (Gerber, 1999). The positivist approach makes claims to absolute truth through the establishment of scientific laws and generalisations. Research questions are concerned with measuring quantities or relative amounts, with a focus on numerical data that are then subjected to statistical analysis.

In contrast, the interpretivist (qualitative) paradigm is based on the belief that there are multiple truths, and it considers historically situated and culturally derived interpretations of the social world. Interpretivist research methods are generally qualitative and use data collection tools such as interviews, focus groups, surveys, observations and documents. Other

major research paradigms or research traditions that underpin research in social sciences include post-positivism, critical social theory (transformative) and pragmatism (Guba & Lincoln, 2005). Critical, constructivist and participatory methodologies are categorised under the interpretivist research paradigm (Guba & Lincoln, 2005).

The aim of the research determines the paradigm because the paradigm creates the link between the aims and methods (Houghton, Hunter, & Meskell, 2012). Selecting a paradigm governs the intent, motivation and expectations for the research. Thus, the paradigm can act as a bridge between the aims and the methods and strategies employed (Houghton et al., 2012). According to Mackenzie and Knipe (2006), the selected research paradigm or theoretical framework is fundamental to the choice of methodology.

Paradigms

When choosing a suitable paradigm, the researcher should ensure that the ontology, epistemology and methodology of the paradigm are manifest in the methods and research strategies employed. (Houghton et al., 2012, p. 39)

Methodology is the research design that shapes the selection and use of particular methods to answer the research aim (Crotty, 1998). The distinction between positivist and interpretivist research occurs at the method level. The main interpretivist (qualitative) research methodologies include GT, discourse analysis, ethnography, narrative inquiry, action research, phenomenology, case study and historical research. Each methodology comprises explicit criteria for the collection, analysis and interpretation of data (Creswell, 2013). Qualitative researchers review research traditions to find the one that best answers the research question or substantive area of inquiry. The focus of qualitative research is on discovery and description, but it can also include verification.

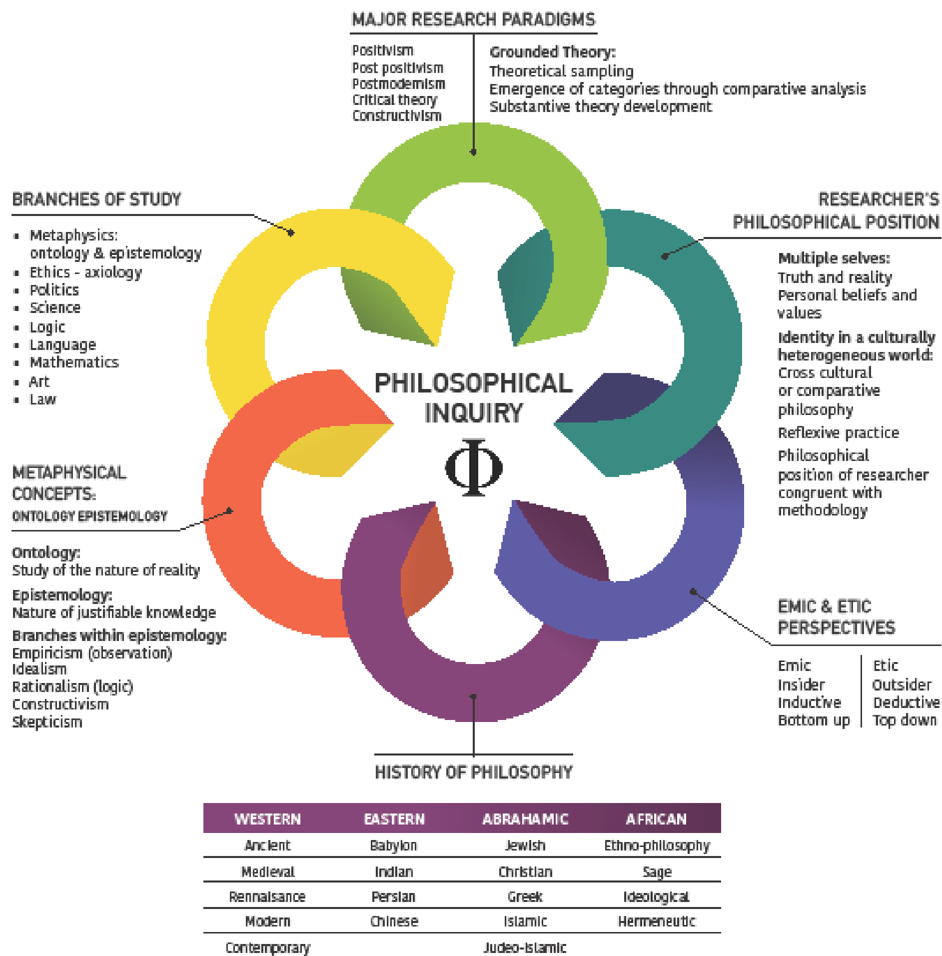
Qualitative research

Qualitative research begins with assumptions, a worldview, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning individuals or groups ascribe to a social or human problem.

To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis is inductive and establishes patterns or themes. The final written report or presentation includes the voices of participants, the reflexivity of the researcher, and a complex description and interpretation of the problem, and it extends the literature or signals a call for action. (Creswell, 2007, p. 37)

Exploring research paradigms and understanding the philosophical assumptions that underpin one's worldview is an important and complex undertaking that must be completed before commencing research. In this study, diagramming the various aspects of philosophical inquiry assisted the researcher to present their personal philosophical journey of discovery as a visual representation of philosophical inquiry. This was akin to joining all of the pieces of the puzzle together.

Figure 3.1 presents the major facets of philosophical inquiry that the researcher explored to ensure that their philosophical position aligned, and was congruent, with GTM. It was constructed by the researcher and was presented at the 14th International Qualitative Methods Conference held in Melbourne, Victoria, Australia in 2014 as the central diagram of a poster presentation titled 'Learning from Each Other: Cross Cultural Philosophy'. In addition, the diagram was included as part of an oral presentation titled 'Working Together: The Integration of Internationally Qualified Registered Nurses into the Australian Healthcare System', which was presented at the same conference.



WESTERN	EASTERN	ABRAHAMIC	AFRICAN
Ancient	Babylon	Jewish	Ethno-philosophy
Medieval	Indian	Christian	Sage
Rennaisance	Persian	Greek	Ideological
Modern	Chinese	Islamic	Hermeneutic
Contemporary		Judeo-Islamic	

Figure 3.1. Facets of philosophical inquiry

Emanating from a congruent philosophy, a methodology is a set of values that underpin the design of the study (Birks & Mills, 2015). The next section focuses on GTM. One of the defining characteristics of GT is its aim to generate theory that is grounded in the data. The next section provides an overview of GT. The history, main genres and essential methods and processes

employed when conducting a GT study are introduced in the next section and further explicated in the published manuscript presented at the end of this chapter.

3.3 Grounded theory

GT represents both a method of inquiry and a resultant product of that inquiry (Bryant & Charmaz, 2007; Charmaz, 2005). Strauss and Corbin (1998) define GT as a 'theory that was derived from data, systematically gathered and analysed through the research process' (p. 12). The researcher begins with an area of study and allows the theory to *emerge* from the data (Strauss & Corbin, 1998). Glaser and Holton (2004) define GT as 'a set of integrated conceptual hypotheses systematically generated to produce an inductive theory about a substantive area' (p. 43). However, Birks and Mills (2015) refer to GT whereby the theory is *generated* from the data analysis. Data and theory are not discovered but are constructed by the researcher, who has particular lenses.

GT is suitable if little is known about the substantive area of inquiry, when a conceptual theory is required and when the research reveals a process intrinsic to the area being examined (Birks & Mills, 2015; Bryant & Charmaz, 2007; Ralph, Birks, Chapman, & Cross, 2014). The emphasis on theory development differentiates GT from other qualitative methods (Strauss & Corbin, 1994). GT is a systematic method of analysing and collecting data to develop the theory. The focus of GT is on data analysis, with early data analysis informing data collection (Charmaz, 2012). GT lends itself to openness to empirical leads that would otherwise be overlooked, allowing the researcher to pursue emergent questions. These empirical leads can shift the course of inquiry (Charmaz, 2005).

3.4 Symbolic interactionism

Symbolic interactionism is a theoretical perspective formulated by Blumer (1969) and consists of a theoretical framework of premises and perceptions to view social experiences (Charmaz, 2014). Symbolic interactionism is the process of interaction in the formation of meaning for individuals. The nursing profession entails interactions between nurses, other healthcare professionals, administrators, government organisations, communities, families, patients and consumers of healthcare. Symbolic interactionism views 'people as active beings engaged in

activities in their worlds and emphasizes how people accomplish these activities' (Charmaz, 2014, p. 262). Each person's understanding of the world is acquired and developed through their interactions with others and the environment (Charon, 2010). Symbolic interactionism 'assumes continuous reciprocal processes occurring between the individual, collectivity, and environment' (Charmaz, 2014, p. 269). Interaction is a symbolic process dependant on 'spoken and unspoken shared language and meanings' (Blumer, 1969). All communication can be viewed as symbolic, based on meaning and interaction where people are best understood in practical relationships between themselves and their environment. Given that symbolic interactionism is dynamic, this perspective acknowledges the 'relativity of varied standpoints and takes into account the subjectivity of social actors as they engage in practical actions in the world' (Charmaz, 2014, p. 269).

Symbolic interactionism has its roots in pragmatism and is the theoretical perspective underpinning the GTM selected for this study. Epistemologically, the researcher identifies with the knower and respondent co-creating understandings (thus constructionism), whereby meaning is not discovered as such, but constructed with the person or object. A pragmatic approach views people interacting with, interpreting and responding to their environment. Thus, symbolic interactionism is the lens through which the researcher views people as interpreting, defining and being active participants in their environment (Blumer, 1969). Therefore, using a symbolic interactionist lens is one perspective in evaluating interactions between people. Reichers (1987) explains newcomer socialisation and describes how symbolic interactionism is used as a theoretical framework to explain processes in organisations:

> A symbolic interactionist perspective on the genesis of meaning and identity is used as a general theoretical framework to explain the specifics of newcomer socialization processes in organizations. This framework suggests that interactions with insiders in the setting may be an important, but largely overlooked, influence on the rate at which newcomers negotiate the first (encounter) stage of the socialization process. The role of interactions between newcomers and insiders is emphasized as the primary vehicle through which initial socialization occurs. (p. 278)

GT aligned with the researcher's pragmatic philosophical position is therefore an appropriate methodology for answering the research question and was subsequently selected as the methodology to underpin this PhD study. The use of GT methods in this study is detailed in the chapters that follow. An outline of the history and genres of GT is presented and further explicated in the published manuscript included at the end of this chapter.

3.5 Design framework for novice researchers

The manuscript titled 'Grounded Theory Research: A Design Framework for Novice Researchers' was written and published as part of this research study. The journal article was developed to present a contemporary view of GT from the perspective of a novice researcher and to provide an exemplar of the research framework that was developed to inform this GT study. GT is not a linear process, and the framework serves to illustrate the interplay between the essential GT methods and the iterative and recursive nature of the actions involved. Each essential method and process that underpins GT is defined in this article. Disseminating the results of a design framework to inform research is valuable for novice researchers. Sharing the experience of conducting research can benefit others through the practical application of knowledge and experience that researchers can use and adjust to suit their own particular research.

The journal article presents a contemporary research design illustrated through a graphic representation of the processes and methods employed in conducting research using GTM. The framework can be readily adapted to suit whichever GT genre is selected. The framework is presented as a diagrammatic representation of a research design and acts as a visual guide for the novice GT researcher. The manuscript includes the research design developed and constructed by the lead author and further refined and adapted to underpin this study. The background includes an overview of the history, genres and research process used in GT.

Grounded Theory Research:

A Design Framework for Novice Researchers

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Grounded theory research: A design framework for novice researchers

Ylona Chun Tie[1], Melanie Birks[1] and Karen Francis[2]

Abstract

Background: Grounded theory is a well-known methodology employed in many research studies. Qualitative and quantitative data generation techniques can be used in a grounded theory study. Grounded theory sets out to discover or construct theory from data, systematically obtained and analysed using comparative analysis. While grounded theory is inherently flexible, it is a complex methodology. Thus, novice researchers strive to understand the discourse and the practical application of grounded theory concepts and processes.

Objective: The aim of this article is to provide a contemporary research framework suitable to inform a grounded theory study.

Result: This article provides an overview of grounded theory illustrated through a graphic representation of the processes and methods employed in conducting research using this methodology. The framework is presented as a diagrammatic representation of a research design and acts as a visual guide for the novice grounded theory researcher.

Discussion: As grounded theory is not a linear process, the framework illustrates the interplay between the essential grounded theory methods and iterative and comparative actions involved. Each of the essential methods and processes that underpin grounded theory are defined in this article.

Conclusion: Rather than an engagement in philosophical discussion or a debate of the different genres that can be used in grounded theory, this article illustrates how a framework for a research study design can be used to guide and inform the novice nurse researcher undertaking a study using grounded theory. Research findings and recommendations can contribute to policy or knowledge development, service provision and can reform thinking to initiate change in the substantive area of inquiry.

Keywords

Framework, grounded theory, grounded theory methods, novice researcher, study design

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Introduction

The aim of all research is to advance, refine and expand a body of knowledge, establish facts and/or reach new conclusions using systematic inquiry and disciplined methods.[1] The research design is the plan or strategy researchers use to answer the research question, which is underpinned by philosophy, methodology and methods.[2] Birks[3] defines philosophy as 'a view of the world encompassing the questions and mechanisms for finding answers that inform that view' (p. 18). Researchers reflect their philosophical beliefs and interpretations of the world prior to commencing research. Methodology is the research design that shapes the selection of, and use of, particular data generation and analysis methods to answer the research question.[4] While a distinction between positivist research and interpretivist research occurs at the paradigm level, each methodology has explicit criteria for the collection, analysis and interpretation of data.[2] Grounded theory (GT) is a structured, yet flexible methodology. This methodology is appropriate when little is known

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about a phenomenon; the aim being to produce or construct an explanatory theory that uncovers a process inherent to the substantive area of inquiry.[5–7] One of the defining characteristics of GT is that it aims to generate theory that is grounded in the data. The following section provides an overview of GT – the history, main genres and essential methods and processes employed in the conduct of a GT study. This summary provides a foundation for a framework to demonstrate the interplay between the methods and processes inherent in a GT study as presented in the sections that follow.

Background

History

Glaser and Strauss are recognised as the founders of grounded theory. Strauss was conversant in symbolic interactionism and Glaser in descriptive statistics.[8–10] Glaser and Strauss originally worked together in a study examining the experience of terminally ill patients who had differing knowledge of their health status. Some of these suspected they were dying and tried to confirm or disconfirm their suspicions. Others tried to understand by interpreting treatment by care providers and family members. Glaser and Strauss examined how the patients dealt with the knowledge they were dying and the reactions of healthcare staff caring for these patients. Throughout this collaboration, Glaser and Strauss questioned the appropriateness of using a scientific method of verification for this study. During this investigation, they developed the constant comparative method, a key element of grounded theory, while generating a theory of dying first described in *Awareness of Dying* (1965). The constant comparative method is deemed an original way of organising and analysing qualitative data.

Glaser and Strauss subsequently went on to write *The Discovery of Grounded Theory: Strategies for Qualitative Research* (1967). This seminal work explained how theory could be generated from data inductively. This process challenged the traditional method of testing or refining theory through deductive testing. Grounded theory provided an outlook that questioned the view of the time that quantitative methodology is the only valid, unbiased way to determine truths about the world.[11] Glaser and Strauss[5] challenged the belief that qualitative research lacked rigour and detailed the method of comparative analysis that enables the generation of theory. After publishing *The Discovery of Grounded Theory*, Strauss and Glaser went on to write independently, expressing divergent viewpoints in the application of grounded theory methods.

Glaser produced his book *Theoretical Sensitivity* (1978) and Strauss went on to publish *Qualitative Analysis for Social Scientists* (1987). Strauss and Corbin's[12] publication *Basics of Qualitative Research: Grounded Theory Procedures and Techniques* resulted in a rebuttal by Glaser[13] over their application of grounded theory methods. However, philosophical perspectives have changed since Glaser's positivist version and Strauss and Corbin's post-positivism stance.[14] Grounded theory has since seen the emergence of additional philosophical perspectives that have influenced a change in methodological development over time.[15]

Subsequent generations of grounded theorists have positioned themselves along a philosophical continuum, from Strauss and Corbin's[12] theoretical perspective of symbolic interactionism, through to Charmaz's[16] constructivist perspective. However, understanding how to position oneself philosophically can challenge novice researchers. Birks and Mills[6] provide a contemporary understanding of GT in their book *Grounded theory: A Practical Guide.* These Australian researchers have written in a way that appeals to the novice researcher. It is the contemporary writing, the way Birks and Mills present a non-partisan approach to GT that support the novice researcher to understand the philosophical and methodological concepts integral in conducting research. The development of GT is important to understand prior to selecting an approach that aligns with the researcher's philosophical position and the purpose of the research study. As the research progresses, seminal texts are referred back to time and again as understanding of concepts increases, much like the iterative processes inherent in the conduct of a GT study.

Genres: traditional, evolved and constructivist grounded theory

Grounded theory has several distinct methodological genres: *traditional GT* associated with Glaser; evolved GT associated with Strauss, Corbin and Clarke; and *constructivist GT* associated with Charmaz.[6,17] Each variant is an extension and development of the original GT by Glaser and Strauss. The first of these genres is known as traditional or classic GT. Glaser[18] acknowledged that the goal of traditional GT is to generate a conceptual theory that accounts for a pattern of behaviour that is relevant and problematic for those involved. The second genre, evolved GT, is founded on symbolic interactionism and stems from work associated with Strauss, Corbin and Clarke. Symbolic interactionism is a sociological perspective that relies on the symbolic meaning people ascribe to the processes of social interaction. Symbolic interactionism addresses the subjective meaning people place on objects, behaviours or events based on what they believe is true.[19,20] Constructivist GT, the third genre developed and explicated by Charmaz, a symbolic interactionist, has its roots in constructivism.[8,16] Constructivist GT's methodological underpinnings focus on how participants' construct meaning in relation to the area of inquiry.[16] A constructivist co-constructs experience and meanings with participants.[21] While there are commonalities across all genres of GT, there are factors that distinguish differences between the approaches including the philosophical position of the researcher; the use of literature; and the approach to coding,

analysis and theory development. Following on from Glaser and Strauss, several versions of GT have ensued.

Grounded theory represents both a method of inquiry and a resultant product of that inquiry.[7,22] Glaser and Holton[23] define GT as 'a set of integrated conceptual hypotheses systematically generated to produce an inductive theory about a substantive area' (p. 43). Strauss and Corbin[24] define GT as 'theory that was derived from data, systematically gathered and analysed through the research process' (p. 12). The researcher 'begins with an area of study and allows the theory to emerge from the data' (p. 12). Charmaz[16] defines GT as 'a method of conducting qualitative research that focuses on creating conceptual frameworks or theories through building inductive analysis from the data' (p. 187). However, Birks and Mills[6] refer to GT as a process by which theory is generated from the analysis of data. Theory is not discovered; rather, theory is constructed by the researcher who views the world through their own particular lens.

Research process

Before commencing any research study, the researcher must have a solid understanding of the research process. A well-developed outline of the study and an understanding of the important considerations in designing and undertaking a GT study are essential if the goals of the research are to be achieved. While it is important to have an understanding of how a methodology has developed, in order to move forward with research, a novice can align with a grounded theorist and follow an approach to GT. Using a framework to inform a research design can be a useful modus operandi.

Results

The following section provides insight into the process of undertaking a GT research study. Figure 1 is a framework that summarises the interplay and movement between methods and processes that underpin the generation of a GT. As can be seen from this framework, and as detailed in the discussion that follows, the process of doing a GT research study is not linear, rather it is iterative and recursive.

Grounded theory research involves the meticulous application of specific methods and processes. Methods are 'systematic modes, procedures or tools used for collection and analysis of data'.[25] While GT studies can commence with a variety of sampling techniques, many commence with purposive sampling, followed by concurrent data generation and/or collection and data analysis, through various stages of coding, undertaken in conjunction with constant comparative analysis, theoretical sampling and memoing. Theoretical sampling is employed until theoretical saturation is reached. These methods and processes create an unfolding, iterative system of actions and interactions inherent in GT.[6,16] The methods interconnect and inform the recurrent elements in

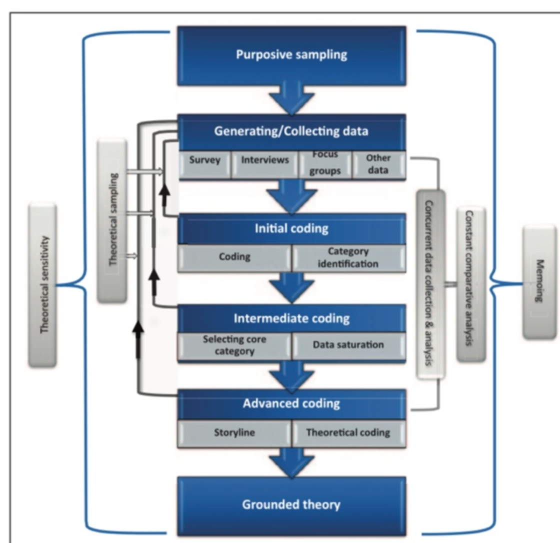

Figure 1. Research design framework: summary of the interplay between the essential grounded theory methods and processes.

the research process as shown by the directional flow of the arrows and the encompassing brackets in Figure 1. The framework denotes the process is both iterative and dynamic and is not one directional. Grounded theory methods are discussed in the following section.

Discussion

Purposive sampling

As presented in Figure 1, initial purposive sampling directs the collection and/or generation of data. Researchers purposively select participants and/or data sources that can answer the research question.[5,7,16,21] Concurrent data generation and/or data collection and analysis is fundamental to GT research design.[6] The researcher collects, codes and analyses this initial data before further data collection/generation is undertaken. Purposeful sampling provides the initial data that the researcher analyses. As will be discussed, theoretical sampling then commences from the codes and categories developed from the first data set. Theoretical sampling is used to identify and follow clues from the analysis, fill gaps, clarify uncertainties, check hunches and test interpretations as the study progresses.

Constant comparative analysis

Constant comparative analysis is an analytical process used in GT for coding and category development. This process commences with the first data generated or collected and pervades the research process as presented in Figure 1. Incidents are identified in the data and coded.[6] The initial stage of analysis

compares incident to incident in each code. Initial codes are then compared to other codes. Codes are then collapsed into categories. This process means the researcher will compare incidents in a category with previous incidents, in both the same and different categories.[5] Future codes are compared and categories are compared with other categories. New data is then compared with data obtained earlier during the analysis phases. This iterative process involves inductive and deductive thinking.[16] Inductive, deductive and abductive reasoning can also be used in data analysis.[26]

Constant comparative analysis generates increasingly more abstract concepts and theories through inductive processes.[16] In addition, abduction, defined as 'a form of reasoning that begins with an examination of the data and the formation of a number of hypotheses that are then proved or disproved during the process of analysis … aids inductive conceptualization'.[6] Theoretical sampling coupled with constant comparative analysis raises the conceptual levels of data analysis and directs ongoing data collection or generation.[6]

The constant comparative technique is used to find consistencies and differences, with the aim of continually refining concepts and theoretically relevant categories. This continual comparative iterative process that encompasses GT research sets it apart from a purely descriptive analysis.[8]

Memoing

Memo writing is an analytic process considered essential 'in ensuring quality in grounded theory'.[6] Stern[27] offers the analogy that if data are the building blocks of the developing theory, then memos are the 'mortar' (p. 119). Memos are the storehouse of ideas generated and documented through interacting with data.[28] Thus, memos are reflective interpretive pieces that build a historic audit trail to document ideas, events and the thought processes inherent in the research process and developing thinking of the analyst.[6] Memos provide detailed records of the researchers' thoughts, feelings and intuitive contemplations.[6]

Lempert[29] considers memo writing crucial as memos prompt researchers to analyse and code data and develop codes into categories early in the coding process. Memos detail why and how decisions made related to sampling, coding, collapsing of codes, making of new codes, separating codes, producing a category and identifying relationships abstracted to a higher level of analysis.[6] Thus, memos are informal analytic notes about the data and the theoretical connections between categories.[23] Memoing is an ongoing activity that builds intellectual assets, fosters analytic momentum and informs the GT findings.[6,10]

Generating/collecting data

A hallmark of GT is concurrent data generation/collection and analysis. In GT, researchers may utilise both qualitative and quantitative data as espoused by Glaser's dictum; 'all is data'.[30] While interviews are a common method of generating data, data sources can include focus groups, questionnaires, surveys, transcripts, letters, government reports, documents, grey literature, music, artefacts, videos, blogs and memos.[9] Elicited data are produced by participants in response to, or directed by, the researcher whereas extant data includes data that is already available such as documents and published literature.[6,31] While this is one interpretation of how elicited data are generated, other approaches to grounded theory recognise the agency of participants in the co-construction of data with the researcher. The relationship the researcher has with the data, how it is generated and collected, will determine the value it contributes to the development of the final GT.[6] The significance of this relationship extends into data analysis conducted by the researcher through the various stages of coding.

Coding

Coding is an analytical process used to identify concepts, similarities and conceptual reoccurrences in data. Coding is the pivotal link between collecting or generating data and developing a theory that explains the data. Charmaz[10] posits,

> codes rely on interaction between researchers and their data. Codes consist of short labels that we construct as we interact with the data. Something kinaesthetic occurs when we are coding; we are mentally and physically active in the process. (p. 5)

In GT, coding can be categorised into iterative phases. Traditional, evolved and constructivist GT genres use different terminology to explain each coding phase (Table 1).

Coding terminology in evolved GT refers to open (a procedure for developing categories of information), axial (an advanced procedure for interconnecting the categories) and selective coding (procedure for building a storyline from core codes that connects the categories), producing a discursive set of theoretical propositions.[6,12,32] Constructivist grounded theorists refer to initial, focused and theoretical coding.[9] Birks and Mills[6] use the terms initial, intermediate and advanced coding that link to low, medium and high-level conceptual analysis and development. The coding terms devised by Birks and Mills[6] were used for Figure 1; however, these can be altered to reflect the coding terminology used in the respective GT genres selected by the researcher.

Initial coding

Initial coding of data is the preliminary step in GT data analysis.[6,9] The purpose of initial coding is to start the process of fracturing the data to compare incident to incident and to look for similarities and differences in beginning patterns in the data. In initial coding, the researcher inductively generates as many codes as possible from early

Table 1. Comparison of coding terminology in traditional, evolved and constructivist grounded theory.

Grounded theory genre	Coding terminology		
	Initial	Intermediate	Advanced
Traditional	Open coding	Selective coding	Theoretical coding
Evolved	Open coding	Axial coding	Selective coding
Constructivist	Initial coding	Focused coding	Theoretical coding

Adapted from Birks and Mills.[6]

data.[16] Important words or groups of words are identified and labelled. In GT, codes identify social and psychological processes and actions as opposed to themes. Charmaz[16] emphasises keeping codes as similar to the data as possible and advocates embedding actions in the codes in an iterative coding process. Saldaña[33] agrees that codes that denote action, which he calls process codes, can be used interchangeably with gerunds (verbs ending in *ing*). In vivo codes are often verbatim quotes from the participants' words and are often used as the labels to capture the participant's words as representative of a broader concept or process in the data.[6] Table 1 reflects variation in the terminology of codes used by grounded theorists.

Initial coding categorises and assigns meaning to the data, comparing incident-to-incident, labelling beginning patterns and beginning to look for comparisons between the codes. During initial coding, it is important to ask 'what is this data a study of'.[18] What does the data assume, 'suggest' or 'pronounce' and 'from whose point of view' does this data come, whom does it represent or whose thoughts are they?.[16] What collectively might it represent? The process of documenting reactions, emotions and related actions enables researchers to explore, challenge and intensify their sensitivity to the data.[34] Early coding assists the researcher to identify the direction for further data gathering. After initial analysis, theoretical sampling is employed to direct collection of additional data that will inform the 'developing theory'.[9] Initial coding advances into intermediate coding once categories begin to develop.

Theoretical sampling

The purpose of theoretical sampling is to allow the researcher to follow leads in the data by sampling new participants or material that provides relevant information. As depicted in Figure 1, theoretical sampling is central to GT design, aids the evolving theory[5,7,16] and ensures the final developed theory is grounded in the data.[9] Theoretical sampling in GT is for the development of a theoretical category, as opposed to sampling for population representation.[10] Novice researchers need to acknowledge this difference if they are to achieve congruence within the methodology. Birks and Mills[6] define theoretical sampling as 'the process of identifying and pursuing clues that arise during analysis in a grounded theory study' (p. 68). During this process, additional information is sought to saturate categories under development. The analysis identifies relationships, highlights gaps in the existing data set and may reveal insight into what is not yet known. The exemplars in Box 1 highlight how theoretical sampling led to the inclusion of further data.

Box 1. Examples of theoretical sampling.

In Chamberlain-Salaun[35] GT study, 'the initial purposive round of concurrent data generation and analysis generated codes around concepts of physical disability and how a person's health condition influences the way experts interact with consumers. Based on initial codes and concepts the researcher decided to theoretically sample people with disabilities and or carers/parents of children with disabilities to pursue the concepts further' (p. 77).
In Edwards[36] grounded theory study, theoretical sampling led to the inclusion of the partners of women who had presented to the emergency department. 'In one interview a woman spoke of being aware that the ED staff had not acknowledged her partner. This statement led me to ask other women during their interviews if they had similar experiences, and ultimately to interview the partners to gain their perspectives. The study originally intended to only focus on the women and the nursing staff who provided the care' (p. 50).

Thus, theoretical sampling is used to focus and generate data to feed the iterative process of continual comparative analysis of the data.[6]

Intermediate coding

Intermediate coding, identifying a core category, theoretical data saturation, constant comparative analysis, theoretical sensitivity and memoing occur in the next phase of the GT process.[6] Intermediate coding builds on the initial coding phase. Where initial coding fractures the data, intermediate coding begins to transform basic data into more abstract concepts allowing the theory to emerge from the data. During this analytic stage, a process of reviewing categories and identifying which ones, if any, can be subsumed beneath other categories occurs and the properties or dimension of the developed categories are refined. Properties refer to the characteristics that are common to all the concepts in the category and dimensions are the variations of a property.[37]

At this stage, a core category starts to become evident as developed categories form around a core concept; relationships are identified between categories and the analysis is refined. Birks and Mills[6] affirm that diagramming can aid analysis in the intermediate coding phase. Grounded theorists interact closely with the data during this phase, continually reassessing meaning to ascertain 'what is really going on' in the data.[30] Theoretical saturation ensues when new data analysis does not provide additional material to existing theoretical categories, and the categories are sufficiently explained.[6]

Advanced coding

Birks and Mills[6] described advanced coding as the 'techniques used to facilitate integration of the final grounded theory' (p. 177). These authors promote storyline technique (described in the following section) and theoretical coding as strategies for advancing analysis and theoretical integration. Advanced coding is essential to produce a theory that is grounded in the data and has explanatory power.[6] During the advanced coding phase, concepts that reach the stage of categories will be abstract, representing stories of many, reduced into highly conceptual terms. The findings are presented as a set of interrelated concepts as opposed to presenting themes.[28] Explanatory statements detail the relationships between categories and the central core category.[28]

Storyline is a tool that can be used for theoretical integration. Birks and Mills[6] define storyline as 'a strategy for facilitating integration, construction, formulation, and presentation of research findings through the production of a coherent grounded theory' (p. 180). Storyline technique is first proposed with limited attention in *Basics of Qualitative Research* by Strauss and Corbin[12] and further developed by Birks et al.[38] as a tool for theoretical integration. The storyline is the conceptualisation of the core category.[6] This procedure builds a story that connects the categories and produces a discursive set of theoretical propositions.[24] Birks and Mills[6] contend that storyline can be 'used to produce a comprehensive rendering of your grounded theory' (p. 118). Birks et al.[38] had earlier concluded, 'storyline enhances the development, presentation and comprehension of the outcomes of grounded theory research' (p. 405). Once the storyline is developed, the GT is finalised using theoretical codes that 'provide a framework for enhancing the explanatory power of the storyline and its potential as theory'.[6] Thus, storyline is the explication of the theory.

Theoretical coding occurs as the final culminating stage towards achieving a GT.[39,40] The purpose of theoretical coding is to integrate the substantive theory.[41] Saldaña[40] states, 'theoretical coding integrates and synthesises the categories derived from coding and analysis to now create a theory' (p. 224). Initial coding fractures the data while theoretical codes 'weave the fractured story back together again into an organized whole theory'.[18] Advanced coding that integrates extant theory adds further explanatory power to the findings.[6] The examples in Box 2 describe the use of storyline as a technique.

Box 2. Writing the storyline.

Baldwin[42] describes in her GT study how 'the process of writing the storyline allowed in-depth descriptions of the categories, and discussion of how the categories of (i) *creating a context for learning*, (ii) *creating a context for authentic rehearsal* and (iii) *mirroring identity* fit together to form the final theory: *reconciling professional identity*' (pp. 125–126). 'The use of storyline as part of the finalisation of the theory from the data ensured that the final theory was grounded in the data' (p. 201). In Chamberlain-Salaun[35] GT study, writing the storyline enabled the identification of 'gaps in the developing theory and to clarify categories and concepts. To address the gaps the researcher iteratively returned to the data and to the field and refine the storyline. Once the storyline was developed raw data was incorporated to support the story in much the same way as dialogue is included in a storybook or novel'.[35]

Theoretical sensitivity

As presented in Figure 1, theoretical sensitivity encompasses the entire research process. Glaser and Strauss[5] initially described the term theoretical sensitivity in *The Discovery of Grounded Theory.* Theoretical sensitivity is the ability to know when you identify a data segment that is important to your theory. While Strauss and Corbin[12] describe theoretical sensitivity as the insight into what is meaningful and of significance in the data for theory development, Birks and Mills[6] define theoretical sensitivity as 'the ability to recognise and extract from the data elements that have relevance for the emerging theory' (p. 181). Conducting GT research requires a balance between keeping an open mind and the ability to identify elements of theoretical significance during data generation and/or collection and data analysis.[6]

Several analytic tools and techniques can be used to enhance theoretical sensitivity and increase the grounded theorist's sensitivity to theoretical constructs in the data.[28] Birks and Mills[6] state, 'as a grounded theorist becomes immersed in the data, their level of theoretical sensitivity to analytic possibilities will increase' (p. 12). Developing sensitivity as a grounded theorist and the application of theoretical sensitivity throughout the research process allows the analytical focus to be directed towards theory development

Box 3. Theoretical sensitivity.

Hoare et al.[43] described how the lead author '*danced with data* in pursuit of heightened theoretical sensitivity in a grounded theory study of information use by nurses working in general practice in New Zealand'. The article described the analytic tools the researcher used 'to increase theoretical sensitivity' which included 'reading the literature, open coding, category building, reflecting in memos followed by doubling back on data collection once further lines of inquiry are opened up'. The article offers 'an example of how analytical tools are employed to theoretically sample emerging concepts' (pp. 240–241).

and ultimately result in an integrated and abstract GT.[6] The example in Box 3 highlights how analytic tools are employed to increase theoretical sensitivity.

The grounded theory

The meticulous application of essential GT methods refines the analysis resulting in the generation of an integrated, comprehensive GT that explains a process relating to a particular phenomenon.[6] The results of a GT study are communicated as a set of concepts, related to each other in an interrelated whole, and expressed in the production of a substantive theory.[5,7,16] A substantive theory is a theoretical interpretation or explanation of a studied phenomenon[6,17] Thus, the hallmark of grounded theory is the generation of theory 'abstracted from, or grounded in, data generated and collected by the researcher'.[6] However, to ensure quality in research requires the application of rigour throughout the research process.

Quality and rigour

The quality of a grounded theory can be related to three distinct areas underpinned by (1) the researcher's expertise, knowledge and research skills; (2) methodological congruence with the research question; and (3) procedural precision in the use of methods.[6] Methodological congruence is substantiated when the philosophical position of the researcher is congruent with the research question and the methodological approach selected.[6] Data collection or generation and analytical conceptualisation need to be rigorous throughout the research process to secure excellence in the final grounded theory.[44]

Procedural precision requires careful attention to maintaining a detailed audit trail, data management strategies and demonstrable procedural logic recorded using memos.[6] Organisation and management of research data, memos and literature can be assisted using software programs such as NVivo. An audit trail of decision-making, changes in the direction of the research and the rationale for decisions made are essential to ensure rigour in the final grounded theory.[6]

Conclusion

This article offers a framework to assist novice researchers visualise the iterative processes that underpin a GT study. The fundamental process and methods used to generate an integrated grounded theory have been described. Novice researchers can adapt the framework presented to inform and guide the design of a GT study. This framework provides a useful guide to visualise the interplay between the methods and processes inherent in conducting GT. Research conducted ethically and with meticulous attention to process will ensure quality research outcomes that have relevance at the practice level.

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3.6 Chapter summary

This chapter presented an overview of the philosophical underpinnings of research paradigms, key methodologies, methods and research processes. An overview of the history of GT and the evolution of different genres of GT was introduced in the published article. The research process and methods required to generate an integrated theory grounded in the data were illustrated and described. The publication included in this chapter outlined the research design developed for use in this study. The next chapter will discuss the application of the GT methods and examine the processes employed in the conduct of this study.

Chapter 4: Methods

4.1 Introduction

GT is the theoretical framework selected to underpin this study. This chapter introduces and describes the research process employed to conduct this research. Essential GT methods were used to generate and collect data. In addition, this chapter explicates the concurrent data analysis using the method of constant comparative analysis to generate the explanatory theory. Figure 4.1 presents a diagrammatic overview of the major processes and methods adopted in this study.

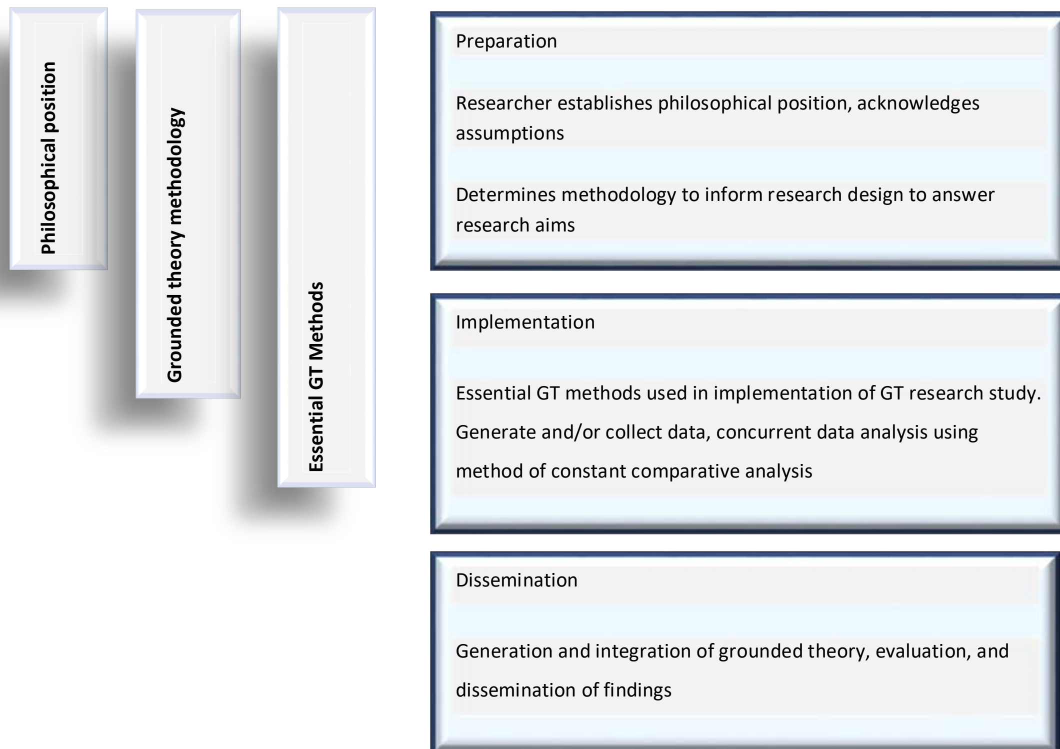

Figure 4.1. Research process using GTM (adapted from Birks & Mills, 2015, Fig 1.1, p. 5)

The following sections detail the researcher's philosophical assumptions that underpin the choice of methods used to generate, analyse and interpret the data for this GT study.

4.2 Epistemology

Before developing the research proposal, the philosophical position of the researcher, as outlined in Chapter 1, was established to provide context for the research design. Positioning the researcher entails identifying assumptions about the nature of reality, how we define

ourselves and how we know or gain knowledge of the world around us. The author of this study considers that knowledge and meaning are constructed between the knower and the known as opposed to being discovered. Thus, knowledge and meaning are co-constructed between the researcher and the participant.

Epistemology provides a philosophical understanding of the nature of how knowledge is acquired. The epistemological stance shapes how the research is conducted, interpreted and disseminated. Thus, it is an important step to discern because different people can construct meaning differently, even in relation to the same circumstance or phenomenon. Ascertaining the underlying philosophy shows where the researcher is positioned and explains how the study design was informed. Figure 4.2 illustrates the steps taken to justify the choice and use of GT methodology and GT methods for the purpose of the study.

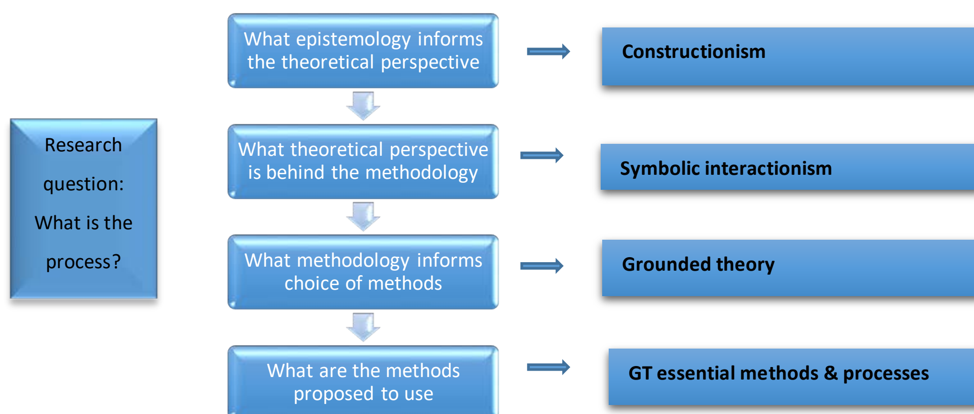

Figure 4.2. Planning a GT study

Constructivism aligned with the researcher's personal philosophical position and was the epistemology that informed the theoretical perspective used in this study. In constructivism, meaning is constructed with the researcher and the participant. Symbolic interactionism was the perspective or the lens through which the research was viewed. Symbolic interactionism involves social interactions that consider the perceptions, attitudes and values expressed in communication, language, interactions with others, and society (Crotty, 1998). Symbolic interactionism underpinned the GT methodology selected for this study. GT methods were used to collect and generate data to answer the research question. The epistemological position of the researcher directed the way in which the methods were used. For example, individual interviews were conducted using an unstructured approach, which enabled the researcher to understand and explain participants' experiences and behaviours within their

social world. During analysis, metaphors were used to explain complex scenarios in understandable and relatable ways. Epistemological issues addressed by Czechmeister (1994, p. 1227) in relation to metaphors state that:

> social phenomena can be interpreted only with understanding of a person or group's subjective, shared and contextual world. The social use of metaphor is best understood within the interpretive paradigm, because 'all thinking is interpretation' (Sontag, 1989), and metaphor itself is one means by which people think about and interpret their world.

Reflexivity is a process that underpins the journey to understanding one's own philosophical position.

4.3 Reflexivity in qualitative research

Reflexivity is a technique that researchers employ to identify their values, beliefs, interests and assumptions before conducting research (Hesse-Biber, 2007). Epistemological reflexivity allows the researcher to ascertain the fundamentals of knowledge—derived from both experience and observation—that underpin the journey to understanding one's own philosophical position. Deep reflection enabled the researcher to think critically in order to articulate and ensure that their philosophical position was congruent with the chosen methodology and supported the research question.

In GT, care is required to prevent confusion between previously held knowledge that is embedded in preconceptions and emerging knowledge from analytical data. As a result, it was imperative for the researcher to identify and document what they knew before commencing the research and to maintain a reflexive approach throughout the research process. The importance of determining and acknowledging preconceptions before conducting research is illustrated by Malterud (2001, p. 484):

> the investigator should take care not to confuse knowledge intuitively present in advance, embedded in preconceptions, with knowledge emerging from inquiry of … systematically obtained material. Declaration of beliefs before the start of the study can avoid such situations occurring

Reflexivity is also the process used by researchers to foster insights into their work to inform future directions, interpretations and upcoming activities (Birks & Mills, 2015). It is an active, systematic process. Reflexivity can be practiced by listening beyond our differences to construct a new set of shared assumptions, or a preparedness 'to remain open' to diverse viewpoints (Hesse-Biber, 2010, p. 418). Before formalising the research design and during the subsequent conduct of the study, the researcher used memos to document assumptions and thoughts regarding what the study might reveal.

4.4 Conducting the study

This section details the process undertaken in the conduct of this GT study. A peer-reviewed research proposal outlined the background, aim and rationale for the study. Inclusion and exclusion criteria were established. Survey questions and a proposed interview question guide were created for inclusion in the research proposal. Ethics approval was obtained before data collection and generation commenced. Data were collected and generated via an online survey, individual interviews and focus groups.

4.4.1 Testing the waters

First, an anonymous online survey was used to determine whether there was sufficient interest in the research topic among RNs and to contribute meaningful data to the study. Second, the online survey was used as a platform to recruit interested RNs for individual interviews and potential focus groups. The online survey therefore served as a recruitment tool. In addition, theoretical sampling of the survey data informed the direction of the study.

4.4.2 Study inclusion and exclusion criteria

Inclusion criteria

1. RNs who obtained their first nursing qualification in Australia and have experience working with IQRNs in the Australian healthcare system.

2. RNs who obtained their first nursing qualifications overseas and have experience working in the Australian healthcare system as an RN.

3. Australian RNs who have worked overseas as an RN.

4. RNs who have come from overseas and gained further qualifications in Australia to be eligible to register to work in Australia as an RN.

Exclusion criteria

Nurses who have not worked in the Australian healthcare system as an RN.

4.4.3 Online survey

RNs, experts in survey design and academic content experts tested the online survey before the researcher submitted the ethics application form to James Cook University's (JCU) Human Research Ethics Committee (HREC). They tested the survey for:

- logical flow of items
- relevance of content
- complexity of questions
- ease of use
- any repetition, redundancy or omissions
- time taken to complete.

Peer feedback, refinement and retesting were used to improve several answer choices to better align with Australian Bureau of Statistics (ABS) descriptors. The order of questions was realigned to improve the logical flow and ease of use following feedback from the retest.

The survey commenced with five demographic questions ahead of the open-ended questions to ease respondents into the survey. Questions related to work, nursing experience and background completed the survey. Participants were given the opportunity to add additional comments at the end of the survey.

Minor revisions to the informed consent forms for the interviews and focus groups were made following a request from the JCU HREC for separate forms for the interviews and focus groups (see Appendix B and Appendix C). A list of questions contained in an interview schedule guide was peer-reviewed by RN experts before submission to the JCU HREC for ethics approval. The chair of the JCU HREC reviewed and approved the survey questions on 5 August 2015 (JCU Ethics approval ID number HREC H6171). The survey contained 28 questions: six open-ended questions and 22 multiple choice demographic questions (see Appendix D). At the end of the

survey, an invitation was extended for participants to contact the researcher via email to express interest in being interviewed or involved in a potential focus group. The email address was not linked to the survey to maintain anonymity of the survey responses.

4.4.4 Ethics

A Low/Negligible Risk Human Research Ethics Application Form was submitted to the JCU HREC following review and approval from a JCU Human Ethics Adviser. The following documents were submitted with the original application:

- Low/Negligible Risk Human Research Ethics Application Form
- Informed Consent Form
- Information Sheet for Participants (see Appendix E)
- Online Survey Questions

Data collection commenced after ethics approval was received (see Appendix F).

4.4.5 Ethics amendment

Any amendments to the original ethics application require approval from the HREC. The Request for Amendment for Research or Teaching Involving Humans Form was submitted to the JCU HREC to expand the recruitment strategy using flyers at nursing conferences and forums. The principal investigator requested the following amendment to the study:

> To expand recruitment of the original approved cohort of nurses for interview and/or focus groups by distributing flyers at conferences or forums (i.e., International Council of Nurses Congress, Australian College of Nursing National Nursing Forum and Australian College of Critical Care Nurses conferences). The recruitment flyer will include information from the original participant information sheet. Where interest is raised at international conferences participants will be interviewed either at conference venues or later by telephone or Skype.

The ethics amendment to expand recruitment was approved by the JCU HREC on 14 March 2017 (see Appendix G). An amendment form request for an extension of time to recruit was granted on 24 April 2018.

4.4.6 Confidentiality and non-disclosure of information

Confidentiality of participants was preserved. No information pertaining to individual participants will be revealed in the dissemination of the results of this thesis or in existing or future publications, conference presentations, media interviews, workshops or seminars. Distinguishing information was de-identified using ciphers known only to the author. Exemplars or in vivo quotes from the interviews, focus groups and survey data that were included in publications or seminar presentations were assigned a pseudonym. Information identifying an individual workplace was de-identified to preserve confidentiality. In addition, sociodemographic data from the anonymous online survey were aggregated for each question to maintain anonymity.

4.4.7 Recruitment

RNs were invited to complete an online survey titled 'Working together: IQRNs in the Australian healthcare system'. The survey was deployed via Australian nursing organisations. Participation was on an informed voluntary basis.

Coalition of National Nursing Organisations

There is a diverse range of national and specialist nursing organisations in Australia. The Coalition of National Nursing Organisations (CoNNMO) represents 55 national specialist nursing and midwifery organisations in Australia. CoNNMO was approached to disseminate the link to nursing organisations. This alliance is supported by the Australian Government Department of Health and aims to represent the interests of nurses across all sectors and to advance the professions of nursing and midwifery (CoNNMO, 2018).

Respondents who accessed the survey were invited to volunteer to be considered to participate in an individual interview and/or a potential focus group. The survey respondents were required to express interest by contacting the principle investigator via email. The online survey responses were not linked to the email address.

4.5 Grounded theory methods

This section describes the GT methods used for the purpose of data collection/generation and concurrent data analysis, which demonstrates congruence with the GTM.

4.6 Data collection and generation

Data collection commenced with the online survey, and responses were received between 17 August and 12 October 2015. The initial number of responses to the online survey (n = 78) indicated that there was sufficient interest in the topic to proceed. Demographic data from the survey indicated that respondents came from each state and territory and worked in a range of areas of practice and healthcare sectors. Interviews (n = 2) were conducted in 2016. Data analysis informed the direction of further recruitment of participants. Further recruitment at nursing conferences led to an additional 108 survey responses received between April 2017 and June 2017. Data were analysed using the method of constant comparative analysis. The use of theoretical sampling resulted in the recruitment of an additional 13 participants for interviews, bringing the total number of interviews conducted to n = 15.

4.6.1 Individual interviews

Participants were emailed an information sheet outlining the purpose of the study before the interviews were scheduled. The participants completed a consent form before participating in an interview with the researcher. Interviews were conducted in person or using information and communication technologies (ICTs) such as telephone or Skype. Individual interviews were conducted at a time and place that suited the participants. Each interview was conducted in English by the principle investigator.

4.6.2 Research interview techniques

Before each interview commenced, the purpose and background of the study were reiterated, which provided an opportunity to ask and respond to any queries. Participants were reassured that confidentiality would be preserved. The question response process was monitored to ensure comprehension of the questions posed, including issues of appropriate vocabulary level, complexity of language and structure of successive questions to use similar language or mirror the participant. Steps were taken to make the participants feel at ease. Providing an atmosphere in which the participant can speak naturally and in their own words aims to remove any undue expectations of what is required in responses in a formal research project.

Once rapport was established, the participants appeared comfortable to disclose answers freely and in depth. However, care was necessary to ensure the participants did not feel judged, that they were not good enough to participate or that they had nothing of real value to offer. Comments in initial conversations—for example, ‘I don’t really have anything very important to say’ and ‘I don’t know if what I say can help your study’—alerted the interviewer. However, once rapport was established and mutual expectations were realised, the conversation flowed easily. Rapport was particularly relevant when speaking with RNs from an NESB or CaLD background.

The interviewer used prompts such as cues and frames of reference to probe deeper to enable the participants to recall events and issues and to provide a more contextual and in-depth response. The following memo was written to reflect on the direction of the questioning.

Memo:

Processing information

Writing up how I conducted the interviews and explaining the cues and prompts used to elicit information with the participants to answer questions consolidated my understanding of the relationship between the methodology, the various data collection techniques employed and their sequencing. When I reviewed the prompts and cues I used and the frame of reference used to construct meaning, I wondered how the participants would view the questions. How is their version or perception of events affected by their background and experiences? Two or more persons can experience the same situation but perceive it differently. What changes or influences the 'lens' through which their perception is gained or viewed?

However, seeing incidents through a different perspective, in essence is reframing how you see the world. Reframing is a powerful and persuasive technique because seeing things from many different perspectives or frames gives you a broader perspective, which in effect allows the researcher to understand more of how participants think. However, it is also important to remember that when examining things from another's perspective, a person's beliefs and values come into play because they are used subconsciously when inferring meaning. This means that when beliefs or values are challenged, change can occur, and the meaning previously ascribed to a situation may change. Thus, a reframing can occur. This means that participants stop, reflect and examine unspoken assumptions (including belief and value systems) and may then use an alternate lens to view a situation in another way. Talking through issues together can uncover their worldview.

In addition, perceptions can change when examining a situation from a perspective not previously considered. However, as the interviewer, I also need to be mindful that there can be several perspectives, which are all valid and legitimate.

4.6.3 Access

The interviews were conducted in a private manner at a time, place and in a mode (in person, via telephone or via Skype) preferred by each participant. Participants were informed that they could withdraw from the study at any time before the final analysis of the data, that they did not have to answer any questions they preferred not to, and that there would be no negative consequences if they withdrew. Confidentiality was assured in the individual interviews. There were no withdrawals of interviewed participants, and each consented to

follow-up questioning if needed for clarification or explication of the data obtained. None of the participants withdrew their consent from the study.

Each interview commenced with a question asking why the participant had volunteered to be part of the study. Following on from the participants' response, open-ended questions were posed to explore the area of inquiry. An unstructured approach, starting with a broad question, was used, commencing with the first interview:

> *Why did you volunteer to participate in this study?*
>
> *Tell me about your experience working in the Australian healthcare system with or as an IQRN.*

The participants' response guided the subsequent questioning using follow-up questions and prompts, such as:

> *Tell me more about …*
>
> *Are you able to give me an example of when this occurred?*
>
> *Who was involved?*
>
> *Where did this occur?*
>
> *How were/are they affected?*
>
> *What do you think could be done differently?*
>
> *Can you describe … ?*
>
> *Do you have any suggestions to … ?*

Demographic questions were asked at the end of the interview. Participants were informed that answering the demographic questions was voluntary and they did not have to answer if they preferred not to.

In keeping with the theoretical sampling that is characteristic of GTM, successive interviewee questions were tailored to follow the leads that arose from the analysis of the interview data.

The duration of the interview recordings ranged between 38 and 84 minutes. Each participant agreed to be contacted by the researcher following the interview if further information or clarification was required.

4.6.4 Pre-planning the interview

Disruptions were minimised by placing a 'do not disturb, recording in progress' sign on the meeting room door. The interviewer's mobile phone was placed on silent mode. Participants were asked to allow one hour for the interview. A confirmation email was sent the day before the scheduled interview to remind the participant that the researcher would be contacting them at a particular time and confirming the preferred number to call or meeting room to attend. This enabled the participants to reschedule if an alternate time was required. The participants appreciated the reminder and a couple of participants had to reschedule for different reasons. Thus, this saved time for the researcher, who pre-prepared the environment and reviewed notes and potential questions or lines of inquiry immediately before each interview. Interviews were conducted in the English language.

4.6.5 Non-native English-speaking participants

While most participants spoke English well, there were several occasions when attention to language and specific words was required by the researcher. Not being fluent in or having mastery of the English language can limit expression, which became evident with some participants from NESBs. It is important to capture participants' intended meaning; therefore, using paraphrasing and asking participants to repeat their responses ensured that their intended meaning was captured correctly. Depth and richness of the obtained data are constrained if participants are unable to find the *right* words in English to accurately express their intent in the Australian context. Thus, as a data collection method, conducting interviews should involve consideration of the cultural aspects and potential challenges involved in interviewing diverse groups of participants.

Several techniques that were employed included asking for clarification if a word or phrase was not understood and paraphrasing a word or term. When the accent was 'thick', asking the participants to spell a word or repeat it slowly ensured that the intended meaning was accurately recorded, which is important for accuracy of the interview transcripts. However, additional time was required. As in clinical practice, the additional time required to

understand can interrupt the normal conversational flow of language between two or more people.

Minimising the potential for power imbalances requires an understanding of power relationships when conducting interviews. The participants included both IQRNs and RNs who have worked in the Australian healthcare system. They were informed that the interviewer is an RN, and they disclosed that in their everyday nursing practice, they often interact and work with RNs from diverse backgrounds, countries of origin and educational backgrounds. Yet it is important not to make assumptions that all RNs have cross-cultural or intercultural communication competence.

4.6.6 Silence in interviews

Silence is often seen as an uncomfortable or unnatural pause in a conversation, and it can be tempting to jump in and fill the silence. However, in research, accepting a pause or period of silence is an important technique to give participants time to recall events or formulate a response to the question posed. Thus, participants were given time to think before responding. Conversely, there were occasions when the participant and interviewer spoke over each other, making transcription difficult.

4.6.7 Interviewing a participant known to the researcher

With globalisation continuing as the new norm and nursing seen as a global workforce, it is not uncommon to meet and work with RNs from previous workplaces. Although this was unanticipated, two participants volunteered to participate in the study because they had previously worked with the principle investigator. The RNs stated that they volunteered because they knew the researcher. Preparing for interviews with participants with whom a researcher had a pre-existing working relationship requires an understanding of the effect of prior knowledge on the research and the researcher (McConnell-Henry, James, Chapman, & Francis, 2009). Consequently, interviews were conducted using the same strict adherence to ethical conduct in a research study.

In addition, as a nurse and a researcher, it was essential to be aware of any dual-role conflict and be cognisant of any undue influence it may have on the research process. Strategies to address the dual role of the nurse and researcher include practicing reflexivity, self-disclosure

of the interviewer's roles, setting boundaries, establishing trust and rapport through respectful dialogue, and preserving confidentiality and privacy of the participants' identity (McDermid, Peters, Jackson, & Daly, 2014).

Reflexivity is the process of critical self-evaluation of the researcher's positionality through continual internal dialogue (Berger, 2015). Such measures avoid issues related to the bias associated with conducting research with participants who have a pre-existing peer or collegial relationship with the researcher, or the researcher's familiarity with a participant's work setting, and it increases the credibility of the research study (Asselin, 2003).

There were several advantages to interviewing persons known to the researcher. For example, it was easy to establish rapport, trust and confidence. The participants stated that they were comfortable disclosing material and information they may not have otherwise disclosed, because they respected the researcher, understood that their confidentiality was assured and were confident of the integrity of the conduct of the research and the researcher conducting the interviews. The participants stated several times that they felt open to responding honestly because they trusted that confidentiality would be preserved. Essentially, the participants anticipated that the researcher understood where they were coming from, was familiar with the environment and the context of where they had worked, and understood the nuances of the work setting around policy, process and staff politics.

An additional consequence was the open disclosure of names and clinical areas that the principle researcher was familiar with; however, they were not the focus of the interview. The participants were assured and trusted that all details and any information disclosed would remain confidential. However, having a familiar understanding of the work units and an intimate knowledge of specific workplaces made it easier to ask more in-depth questions. Being familiar with some of the processes and policies of particular institutions, facilities and workplaces that had been previously worked at or visited provided additional insights into the participants' responses.

Charmaz (2006, pp. 2–3) stated:

> We try to learn what occurs in the research setting we join and what our research participants' lives are like. We study how they explain their statements and actions, and ask what analytic sense we can make of them.

Yet the opposite effect can occur when a participant knows the researcher and fears that their responses may be secretly judged. Responses to questions are modified to reflect what participants think the researcher wants to hear. However, this may also occur for any participant in a research study. In addition, participants may not want to expose any difficult or unpleasant aspects of nursing practice that they have experienced or witnessed, even when specifically asked. Participants may withhold or reserve information for several reasons, including apprehension at disclosing an unpleasant experience, being seen as contributing to or condoning a particular incident and a fear of how they or their clinical practice will be perceived. Expertise in interviewing techniques can allay some of these causes and improve the quality and depth of the information obtained.

Memo

Limiting bias in participant selection.

It was important to me as a researcher not to turn away participants who volunteered to be interviewed if they met the criteria of the study. While only a small number were familiar to me, it was important that they were treated the same as any other participant. Yet when they spoke to me, it almost felt like a confessional for them—a cathartic release to say what they really felt about their experiences of self and others. It is humbling yet important to me that I get this right for them and for all nurses … The enthusiasm for the study meant that some participants were also able to recruit other interested participants.

4.6.8 Interview notes

Notations were written as each interview was conducted. Non-verbals were noted when interviews were conducted in person or via Skype. Any incongruence to what was said was able to be gauged. Further questions were asked to clarify the intent of the participants' words and to ensure the ascribed meaning was accurately reflected. This was important when the participants used metaphors to describe or explain a process. Anything of interest and any points of difference were jotted down. Questions that arose during the interview were noted for clarification or validation, either later in the conversation so as not to interrupt the flow, or for use in subsequent interviews.

4.6.9 Field notes

Field notes were written immediately after each interview concluded. The overall first impression of what was said, including the sense from the participant of what was important to them, was noted and captured in a memo. A summary was written of the key ideas based on the overall impression of the meanings that the participant conveyed and the researcher's reflection and recollection. The tone of voice, language used and intensity of the conversation and content were also noted. The field notes were written to capture the overall meaning rather than the exact words. They were instrumental in capturing participants' key concerns. These data were used in the concurrent data generation and analysis to determine how the key concerns raised were resolved and to determine the processes that were employed to resolve them.

4.6.10 Interview transcripts

Each recorded interview was transcribed word for word and time stamped by a professional transcription service. Once the transcript was received, it was reviewed and played back to ensure accuracy and answer any questions the transcription service had regarding unclear terms or words used. This proved to be an important step because words or phrases that are not accurately transcribed can significantly alter the intended meaning. Table 4.1 presents a summary of the errors made during the transcription of the recorded interviews.

Table 4.1. Transcription Errors Exemplar

Correct word/s—	Incorrect transcription
Embarrassed—	imbalanced
Quit—	recruit
You—	them
Accept—	precept
Continue—	contribute
Learning—	weaning
Two levels—	a key level
Effective—	less effective
Discussion—	discomfort of it
It was—	if there was
Being—	bring
Know them—	none of them
Suggestion—	rejection

In addition, entire fragments of the conversation were omitted from sentences. For example, '… bonuses for people recruiting …'. Such omissions can make a significant difference to the analysis and alter the potential direction of the research.

Memo

While coding the interviews that were transcribed by a professional transcriber service, I sensed something was not quite right in one interview transcript. Until that time, each transcript had been checked against the original recording to ensure accuracy. However, for one interview, my recollection of the meaning of what was said was different to what I was reading. I listened to the original recording while reading along with the transcript, which alerted me to transcription errors and the need to review the transcripts very closely. Even when the interviewee spoke native English and the sound quality was not an issue, many errors were picked up, which made a significant difference to the final transcript to be coded. The differences in what was transcribed and what was actually said took me by surprise. This demonstrates the importance of meticulously checking every word to ensure the data are captured precisely and the content is preserved as accurately as possible.

The next section details the initial coding process that was undertaken, commencing with the first interview. In essence, the data were fractured to be able to compare incidents and look for patterns and similarities in the data.

4.7 Coding

Individual interview transcripts were entered into NVivo and coded for processes in the area of interest that were relevant to the research question. The first interview was coded line by line and incident by incident. Gerunds (words ending in *-ing*) were used in the initial coding to represent processes in the data. When the participants' exact words were used as a code, they were written in italics to identify the code as an in vivo code. Thus, the interview data were coded, and labels were attached to segments or words from the transcripts that described a process. Consequently, 141 codes were generated from the first transcripts coded in 2016. However, several initial codes were predominantly descriptive as a result of wanting to remain open to what could emerge and not risk precluding information that could be relevant to the developing theory.

The first three interview transcripts were coded separately to enable coding to be conducted without undue influence of previous codes that were undertaken to allow the researcher to develop and refine their coding skills. As the coding commenced, it was important to not force the data into a preconceived code from a previous interview. However, it became evident early on that similar processes were being coded. Each interview transcript that was coded resulted in many codes. New codes were established and compared with existing codes. Questions arose from each interview that were used to generate more data in the subsequent interviews.

The constant comparative analysis technique was used to compare each code with the other codes. An NVivo coding map constructed from the initial data was revised as new data were collected and coded. Each code was given a refined descriptor as a definitional statement and documented in a coding book. However, repetition became apparent as the analysis progressed, and patterns were forming in the data. Patterns became evident and codes were compared with other codes to look for and identify relationships between them. Writing

analytic memos remained significant at this stage. Concurrent data collection and generation continued as further interviews were conducted.

Memoing analytic thoughts and ideas concurrent with the coding process was necessary to identify higher-order conceptual abstractions. As a result, some initial codes were recoded or collapsed into new codes or subcategories, resulting in a reduction of codes. Memos were crafted about each code, including ideas or thoughts that occurred while comparing the codes and developing categories. Each interview transcript that was coded added more codes and subcategories and categories. Analytic memos were written to document the process and create an audit trail. Codes and subcategories were collapsed, and the categories became more theoretical as the level of analysis became more analytical and abstract. Levels of abstraction were built upon as new data were generated to check and refine the categories.

Memo

Being immersed in the data that had been collected and generated was both uncomfortable and exciting. There was a need to ensure that the data were recorded accurately and that the subsequent analysis and interpretation were a true reflection of the data and the amount of data collected and generated from the interviews. Hundreds of codes were developed, and the comparative stage of comparing incidents was overwhelming at times. Memos stretched into a hundred pages. The balance between following leads to what I thought was going on and allowing myself to trust and go with my gut instinct left me feeling excited but also with a sense of dread. My uncertainty and self-doubt reflected the powerful inner conviction to analyse the data accurately. To concisely articulate what I thought was going on in the data proved to be a challenging exercise, but it became a defining moment in writing the storyline. The rereading and listening to the original transcripts after the initial coding, checking again for details about the overall or general sense of what the main message or data is saying. But for me, more significantly it was about comprehending what was not said directly, but reading between the lines. Looking for what was not said overtly and looking for any hidden meaning that would provide further insights into what was occurring in the interview data.

I learned that the interpretation of the data is the researcher's interpretation; it is not an exact replication of the data. In essence, it is the translation of other people's words, dialogue and actions that convey meaning. Once I acknowledged this and trusted my instincts, the process became more manageable. Writing memos was inherent to and aided this process.

Throughout the research process, constant comparative data analysis was performed until codes, categories and the core category were identified and abstracted from the data.

Figure 4.3 illustrates the levels of conceptual abstraction leading to the GT.

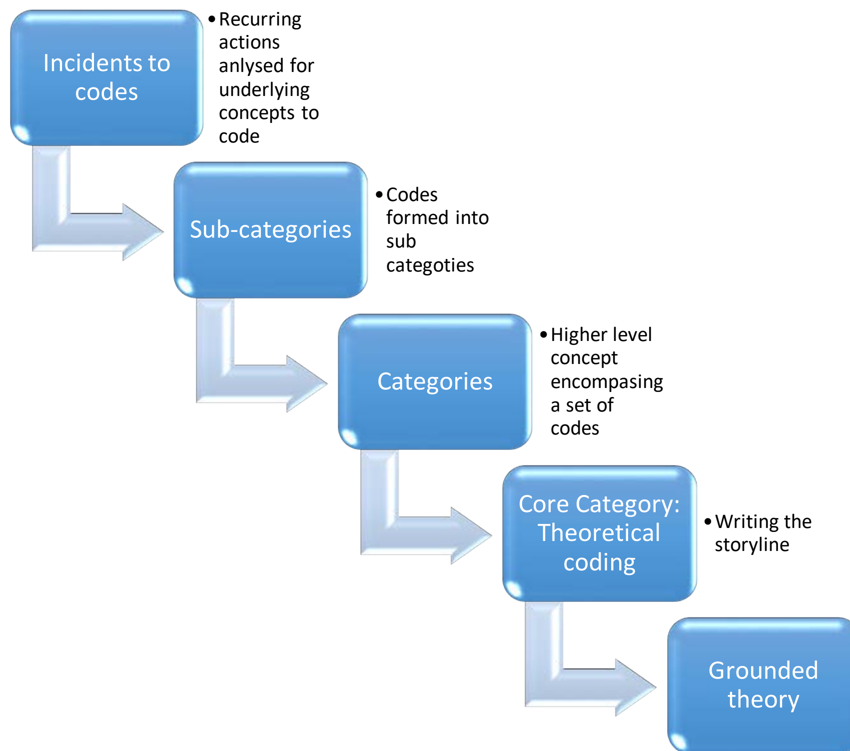

Figure 4.3. Concept levels leading to a substantive GT

4.8 Category identification

An exemplar outlining the initial coding process is detailed in Table 4.2.

Table 4.2. Coding Interview Transcripts: IQRNs Expectation and Experience of Working in the Australian Healthcare System

Context: Workplace setting		
Incident to codes	**Subcategory**	**Category**
Recognising experience and qualifications	Realigning scope of practice	Orientating to new norm
Not being acknowledged Needing more information Attending education	The IQRNs experience Assisting others Finding a way	Adapting to the workplace
Experiencing bias	Being different Accepting difference	Becoming socialised to a new workforce
Feeling alone Asking for help	Seeking support Feeling supported	Getting support

Memos were written to reflect the thinking and ideas generated from the initial codes from the interview transcripts. Sampling the online survey data and the concurrent analysis uncovered deeply embedded contextual barriers and facilitators to integration from the perspective of AQRNs and IQRNs. Comparing and contrasting the contexts, it became evident that the voices of IQRNs from NESBs were needed.

4.9 Following leads in the data: ethics amendment

An amendment form was submitted to the JCU HREC to increase recruitment to include RNs from NESBs and CaLD backgrounds and RNs with English as a second language (ESL). The ethics amendment submitted to the JCU HREC (March 2017) to expand recruitment via flyers at conferences and forums was approved. Following the HREC's approval, flyers were used to recruit additional participants at international (International Council of Nurses Congress, Barcelona, Spain), national (ACN National Forum, Sydney, New South Wales, Australia) and state (Rural Health Conference, Cairns, Queensland, Australia) nursing conferences throughout 2017.

Interest in the study from conference attendees resulted in an additional number of RNs completing the online survey. RNs successively contacted the researcher and expressed interest in being interviewed. Subsequently, RNs, including those from an NESB and CaLD background, were interviewed following receipt of a signed consent form.

Transcripts were analysed concurrently, new codes were developed and existing codes were collapsed into subcategories and categories. Each incident coded in the transcript was compared with previous codes and categories, new codes and categories were formed, codes were collapsed, and subcategories and categories were constructed. Each code had an explanatory statement describing exactly what the code represented. The method of constant comparative analysis was undertaken along with theoretical sampling and memoing. A code book was used to record the codes from the interview transcripts. The codes were recoded and refined into categories as the analysis progressed.

Interviews ceased after n = 15 because no further insights were obtained from the analysis of the transcripts, and no new information was received from the participants. Data saturation was achieved when no new insights were obtained from participants and the categories were

sufficiently explained (Glaser & Strauss, 1967; Malterud, Siersma, & Guassora, 2016). Malterud et al. (2016, p. 1758) explain data saturation in GT:

> *Saturation* is often mentioned as a criterion for sample size in qualitative studies (Morse, 1995). The concept has been presented as an element of the *constant comparative method*, which is a central element of GT, intended to generate theories from empirical data (Glaser & Strauss, 1999). During data collection, the researcher compares sequentially added events until exhaustive saturation of properties of categories and of relations among them is obtained (Charmaz, 2006). Furthermore, theoretical sampling based on preliminary theory developed in the study is required for saturation in a GT analysis to finally arrive at saturation. Saturation occurs when the researcher no longer receives information that adds to the theory that has been developed.

4.10 Constant comparative analysis

The method of constant comparative analysis was used, which involved making comparisons of each code or category during each stage of the analysis. Undertaking comparative analysis and constructing categories advanced the progress of the research using inductive and abductive logic.

4.11 Theoretical sensitivity

Theoretical sensitivity was used to identify relevant data to support the developing theory. While theoretical sensitivity reflects the researcher's level of insight into the area of research, it also reflects the level of insight into themselves. It was important to understand this before conducting this research. Acknowledging preconceived ideas was an essential first step before commencing the study. Memos were written early on to preclude bias or potential bias that could influence the study. The theory needs to come from the data and not the researcher's preconceived thoughts or ideas. Interview transcripts and survey data resulted in hundreds of pages of data. The researcher used theoretical sensitivity to recognise which elements of the data were important and relevant for the developing theory. As the research progressed, the

researcher became immersed in the data, and the degree of theoretical sensitivity increased, which led to an advance in analytic possibilities.

4.12 Intermediate coding

Initial codes from the interview data were compared. Intermediate coding identified relationships between codes and patterns during category development. However, the coding moved between initial and intermediate coding in keeping with concurrent data analysis and collection/generation and constant comparison of data. During intermediate coding, memos and field notes were organised and sorted to aid integration by identifying relationships and unifying concepts. Relationships were identified between codes when concepts from the data were developed in terms of properties and dimensions. Properties are characteristics that 'define and describe' a concept, whereas dimensions are 'variations within properties that give specificity and range to concepts' (Corbin & Strauss, 2008, p. 159). Concepts are words that stand for ideas contained in the data. They are interpretations and the product of analysis (Corbin & Strauss, 2008). The properties and dimensions of each code were compared, codes were collapsed and new categories were formed. Subcategories were compared and linked to categories. This was achieved by comparing the properties and dimensions of the codes and subcategories. The development of categories during the phase was achieved. Table 4.3 presents an exemplar of the initial subcategories and categories.

Table 4.3. Subcategories and Categories Exemplar

Category	Subcategory
Invisible social structures	Listening to difference Hearing otherness The rhythm of language Unspoken frustration
Transitioning to practice	Acting together Adapting to new ways Adjusting self Supporting colleagues
Adapting to cultural context	Learning the local language Becoming socialised
Re/Aligning scope of practice	Defining the RN role Understanding scope of practice Meeting expectations
Playing by the rules	Challenging stereotypes Observing from the periphery Fitting in
Collaborating for quality care	Confronting barriers Communicating styles Finding a way

4.13 Advanced coding

During advanced coding, analytic memos and field notes were sorted to assist in the process of identifying coalescing or unifying concepts and their relationship with the core category. Storyline was used as an analytic technique to describe and explain each of the main categories and the link to the core category. The guiding principles of storyline, as outlined in Figure 4.4 using the TALES acronym, were used to ensure it was an accurate representation of the data within which it was grounded (Birks & Mills, 2011).

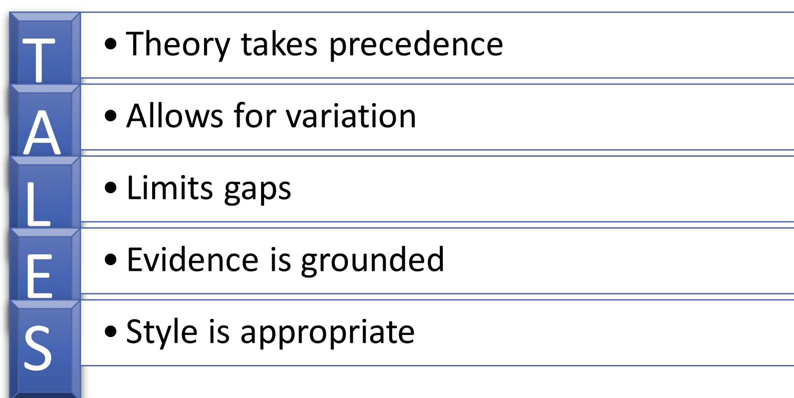

Figure 4.4. TALES adapted from Birks and Mills (2011, p. 119)

Storyline was used as a tool for theoretical integration to assist in the production of an abstract (theoretical) explanation of the findings of this study. A key element of advanced coding is theoretical coding (Glaser, 2013; Thornberg & Charmaz, 2014). While the properties of the core category emerged during the analysis, finding an accurate label for the core category proved difficult. A metaphor is one way to present abstract concepts so they can be understood (Yu, 1998).

Metaphors are a 'powerful and effective use of language' to convey meaning (Czechmeister, 1994, p. 1226). They make abstract concepts more plausible and understandable when explaining complex processes (Czechmeister, 1994). The decision was made to use a metaphor for the theoretical code to assist in explaining the connection between the categories and to increase the explanatory power of the developing theory. In GT, metaphors 'can be used as theoretical codes' if there is sufficient fit (Birks & Mills, 2011, p. 126). Metaphors were able to be used for the theoretical code in this study because there was sufficient fit between the metaphor and the theory. Metaphors can be used to explain a theory 'by clarifying relationships and providing labels for various components' (Birks & Mills, 2011, p. 126).

4.14 Theoretical saturation

Theoretical saturation of subcategories and categories was achieved after further theoretical sampling. Theoretical saturation occurred when no further insights were obtained from the additional data and the categories were sufficiently explained. The aim of this GT was to explain the process of integration and present a comprehensive explanation of this process. The core category is a highly abstract concept selected to encompass and explain the GT.

Memo

I was actively listening, but in the last three interviews I knew that the same issues were being raised and it was obvious that no new insights were forthcoming. I had to concentrate to keep listening actively and intently over the phone because I was thinking 'yes, this validates everything that I have heard before, so what questions can I ask to see if there is anything new or different that I can explore further?' But when no new insights were gained, I realised I had reached theoretical saturation. The last interview conducted lasted less than 40 minutes.

4.15 Focus groups

Participants who had been interviewed or recruited at nursing conferences were invited to express interest in participating in a focus group, which were used to test and evaluate the theory. Two focus groups were conducted in 2018, with each session lasting 60–90 minutes. There were nine participants in the first group and seven in the second group. Participants could choose to participate in person or via ICT. A video link via the Zoom platform was extended for those unable to participate face to face. Given that participants were invited from each state and territory in Australia, and considering the distances, time and costs involved to attend in person, a video link was considered a viable alternative (Flynn, Albrecht, & Scott, 2018). Links were tested for audio-visual access to troubleshoot any issues before the focus group began to give all participants the opportunity to participate fully.

> *Despite the benefits of using videoconference technology to conduct focus groups, it is important to consider the following issues: the research context, the preference of the participants, the researcher–participant relationship, technical issues, the confidentiality and consent of the participants, recording and transcribing, and the availability and accessibility of the videoconferencing service. From our research experience, videoconferencing provides a viable solution for conducting focus groups in certain research contexts. Examining the influence of participants being able to see themselves on screen in the online audio-visual focus group would be useful, and the impact that familiarity with the technology has on participation and data quality are all important areas for future research*. (Flynn et al., 2018)

Consent forms were completed by all participants before attending the focus group. The sessions were conducted by the lead researcher and moderated by an adviser of the research panel. The focus groups were audio-recorded with consent. The purpose of the focus groups was to test and evaluate the theory. The following criteria for evaluating GT studies were used, as advocated by Charmaz (2014, pp. 337–338):

- credibility
- originality
- resonance
- usefulness

These criteria address the inherent actions and processes in the studied phenomenon of integration and give meaning to how the theory was constructed and developed. The consensus from both focus groups was that the theory conceptualised and conveyed a meaningful rendering of the process of integration and made a valuable contribution to the nursing profession. A full evaluation of the final theory is provided in the final chapter.

4.16 Data storage and management

The research data management plan included data organisation, backup, security of confidential data and archiving data in a format that can be retrieved in the future. Data included online survey responses, individual interview and focus group recordings, interview transcripts, coding, analytic and procedural memos, meeting notebooks, field notes, draft manuscripts and written materials. The researcher and advisory panel had access to this information. The professional transcription service employed to transcribe the recordings was bound to industry standards to ensure confidentiality of the material was maintained. The transcribers were required to sign a confidentiality clause. Three copies of all PhD data were made and stored in separate locations. Data were stored on the hard drive of the researcher's JCU computer, an external hard drive and password-protected network storage, including JCU OneDrive.

The researcher adhered to the Australian Code for the Responsible Conduct of Research to manage and secure the data. Data management plans included what data were collected and how they were stored (e.g., what format and how long the data would be stored).

4.17 Data management plan

Raw data (e.g., completed surveys) are stored in accordance with the NHMRC/Universities Australia 'Australian code for the Responsible Conduct of Research', 2007 and Queensland State Archives legislation (6.8.3.).

Raw data for this study will be retained for at least five years. Any data that are stored on computers, USBs and external hard drives will be de-identified and password-protected.

Signed Informed Consent Forms from this study will be retained for 15-years.

During and upon completion of the study, raw data will be stored in a locked filing cabinet in the principal investigator's office in the Nursing and Midwifery building at JCU.

Data were backed up using SyncBack to an external hard drive, which is kept in a fireproof safe at a location away from the university at the principle researcher's residence.

Data were backed up to the principal investigator's local network file server storage and will also be saved to external data storage (i.e., Australian Research Collaboration Service cloud computing) as necessary.

The principal investigator has completed all compulsory JCU Graduate Research School sessions: Induction Day; Preparing for Confirmation of Candidature; Professional Writing and Editing; Research Integrity; Plagiarism and 'Safe Assign'; Data Storage and Management; Intellectual Property and Copyright; Overview of Workplace Safety Requirements; Effective Candidature Management; and Contextualising the Research.

4.18 Use of computer-assisted software NVivo

Qualitative data analysis software program NVivo was used as a repository for the organisation and management of the research data, analytic and procedural memos and extant literature. However, the analysis was undertaken by the lead researcher.

4.19 Evaluation of the research process

The criteria for the evaluation of the research process in GT encompasses researcher expertise, methodological congruence and procedural precision (Birks & Mills, 2015, pp. 147–148). Procedural precision was achieved through maintaining an audit trail of the decisions made in the conduct of the study. Memos were written to create a timeline of factors that influenced decisions-making, thoughts and reflections of the research process, analytical decision-making, coding and category development, theoretical sensitivity, informed theoretical sampling and the developing theory. Management of data and resources was done in a logical and secure manner using NVivo software as a repository for data including memos, interview transcripts, field notes and other documents such as journal articles and books.

Careful adherence to and meticulous application of the essential GT methods ensured procedural precision in the conduct of this study.

4.20 Chapter summary

This chapter described the research methods and processes used in the conduct of this study. GT methods were used to obtain and analyse data to explain the process of integration and deliver an explanatory theory grounded in the data. In the next chapter, the theory will be explicated using the analytic technique of storyline. Further, a diagrammatical outline of the theory will be presented as a visual overview.

Chapter 5: Findings

Midway between the unintelligible and the commonplace, it is a metaphor which most produces knowledge. (Aristotle & McKeon, 1941, Rhetoric 110)

Thought flows in terms of stories—stories about events, stories about people, and stories about intentions and achievements. The best teachers are the best storytellers. We learn in the form of stories. (Smith, 1990)

5.1 Storyline

Storyline is a technique used in GT 'for facilitating the integration, construction, formulation and presentation of research findings through the production of a coherent grounded theory' (Birks & Mills, 2011, p. 176). The *playing the game* theory constructed from this GT study explains the process by which IQRNs are integrated into the Australian healthcare system. Theoretical constructs that explain relationships between activities and processes in the data are presented in each of the major categories. This GT explains the process of integration and adaption of international nurses into a foreign healthcare system from the perspectives of local nurses and international nurses. The developed theory of *playing the game* explicates each phase of the integration process using metaphors (see Figure 5.1). The GT is constructed from the following categories:

(i) *Joining the game:* observing and learning the cultural norms—adapting to context
(ii) *Learning the game*: adjusting to a new norm—becoming socialised
(iii) *Playing by the rules*: becoming the norm—aligning scope of practice
(iv) *The end game*: un/successful integration—win, lose or draw.

Metaphors are a useful and creative way of framing complex processes in nursing (Rolfe, 2018). In this study, the metaphor *playing the game* assists in understanding the theoretical relationship between the main categories in the GT. The use of storyline and theoretical coding using metaphors serves as the link between analysis and theory. The metaphor used as a theoretical code adds explanatory power to the final theory (Birks & Mills, 2011). *Playing the game* was an in vivo code that crystallised the process from the perspective of those that experienced the phenomenon (Chun Tie, Birks, & Francis, 2018).

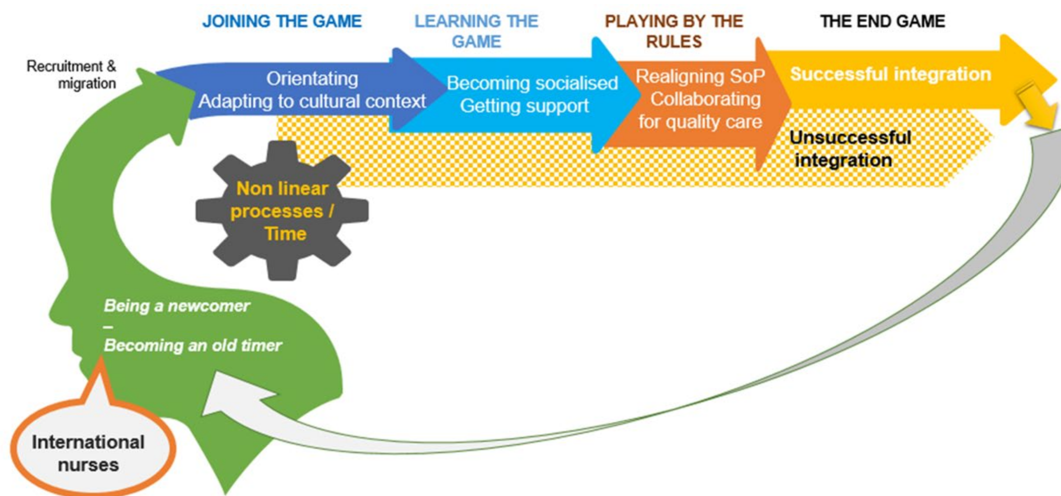

Figure 5.1. A GT of the integration of international nurses in the Australian healthcare system

The following excerpt from a study by Chircop and Scerri (2018, p. 2623) presents a backdrop to how metaphors are used in healthcare settings:

> Metaphors have an important role in enabling complex and abstract concepts to be better understood, through a comparison with more familiar concepts (Harrington, 2012). This central function of the metaphor is often referred to as 'framing'. Semino et al. (2016) state that there are three different perspectives on metaphor that consider these framing effects: cognitive, discourse-based and practice- based. The cognitive perspective was developed by Lakoff and Johnson (1980), who examined how individuals use metaphors to think about different kinds of experiences. On the other hand, studies that adopt the discourse perspective (Cameron, Low, & Maslen, 2010; Ritchie & Cameron, 2014) investigate the different forms and functions of metaphors in language by considering who uses them, why, in what contexts and with what possible effects and consequences. While the practice perspective focuses on how metaphors can help or hinder communication in particular institutional settings (e.g., healthcare) and thus, identifies which metaphors should be used and which should be avoided (Reisfield & Wilson, 2004). Nevertheless, in all three perspectives metaphors are used as vehicles for understanding that can bridge the communication gap between patients and healthcare professionals (Semino et al., 2016). Patients can use metaphors to reveal certain aspects of their illness experience, such as when communicating their emotions or experiences, that are otherwise inexpressible. Conversely, healthcare professionals can harness the explanatory power of metaphors

when presenting medical concepts that are unfamiliar to patients. Moreover, nurses can use metaphors as tools to enhance their understanding of patients' experiences and thus, provide patient-centred care (Harrington, 2012).

Imagery and metaphors are used throughout health communication. Metaphors used in health communication can create shared meaning and can be persuasive (Harrington, 2012). In this study, the metaphors used within the GT *playing the game* provide an explanatory scheme. The GT is presented in a diagram as a visual representation of the theory and the processes it embodies.

The metaphor of *playing the game* links professional socialisation and value clarification with professional role identity. The RN develops and clarifies the values that underpin their practice during professional socialisation. Professional values are underpinned by attitudes and beliefs that then lead to actions. Actions in turn lead to alignment of professional practice, including standards of care and role identity. Realigning expectations of the RN's role in the Australian context occurs and includes cultural beliefs, PCC, communication styles and scope of practice variance.

Socialisation occurs as IQRNs reconcile the difference in nursing practice in Australia with their home country and AQRNs welcome new knowledge and understanding of how healthcare is delivered in other health systems. Value congruence, acculturation and adaption to organisational norms occurs; however, there is not always congruence between the IQRNs' values and organisational values.

Processes in the GT *playing the game* are nonlinear, with fluidity of movement between categories and over time. The key constructs in this GT link organisational and professional socialisation contexts with the sociocultural process of adaption (behaviour) underpinned by the socioecological concept of social capital (social skills).

5.2 Joining the game

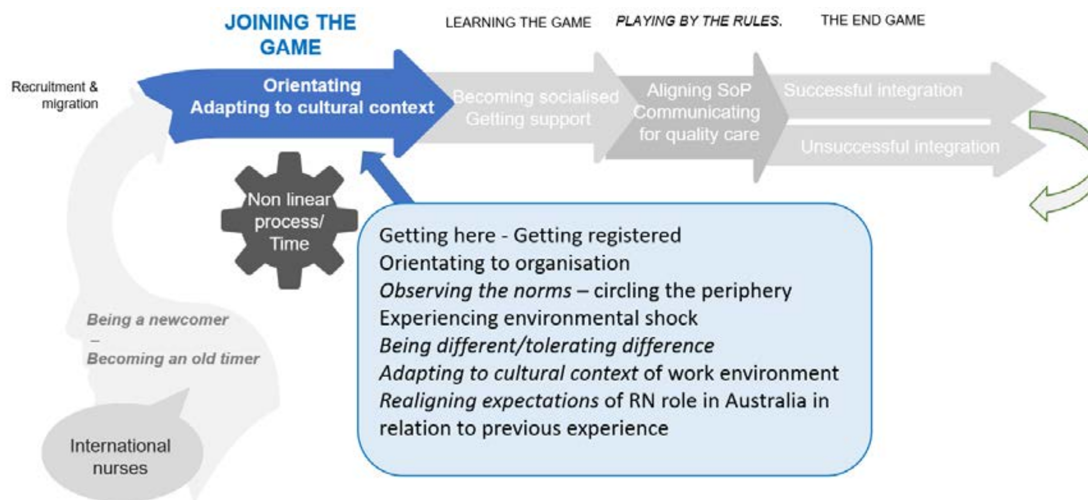

Figure 5.2. Joining the game

Nurses migrate to Australia from diverse cultures and backgrounds and have a range of experiences, knowledge and skills. To transition into a foreign healthcare system, nurses need an understanding of the expectations and cultural norms of clinical practice in the local context. Although IQRNs who commence work in the Australian healthcare system are experienced nurses, differences in educational preparedness, models of care, scope of practice, cultural values and beliefs, and English language mastery can require an adjustment from previously held norms. Seeking information to navigate context, practice and hierarchical relationships requires knowledge of the cultural norms of the workplace setting. Achieving this knowledge occurs through formal channels (e.g., orientation and transition programs), informal means (observing, being intuitive, exhibiting emotional intelligence, having self-initiative, being savvy) and forming social or community connections.

A collective understanding of the RN's role within local work contexts is crucial. Observing workplace norms involves an understanding of professional socialisation factors (internal values, culture and behaviours) and organisational socialisation factors (described in in vivo codes *fitting in*, *connecting with colleagues*, *learning the organisational culture* and *learning the formal and informal rules of the practice environment*). In nursing, a sense of belonging and professional identity contributes to professional socialisation. Socialisation factors are underpinned by interpersonal skills, which influence the experience of orientation and transition to new work environments.

The development of a deep, shared understanding of the expectations and cultural norms of the workplace occurs by learning through observation, involvement and information-seeking by both IQRNs and the nurses they work with. An understanding of the cultural norms and expectations of clinical practice requires workplace-appropriate support such as unit-specific orientation and education, particularly in specialty practice areas. Supportive workplace practices include supernumerary shifts, access to experienced peer or mentor support persons, clinical educators, and organisational and managerial promotion of positive learning environments for both IQRNs and existing RNs. IQRNs and RNs who have an open, positive attitude enable transition to occur more successfully.

Commencing work in a new healthcare system can be both exciting and stressful for IQRNs and the existing nursing workforce. Organisations facilitate adjustment via orientation programs to reduce stress and anxiety during the orientation and transition phase. However, despite generic orientation programs, supernumerary shifts and clinical educator support, it is the general cultural environment that determines or influences the success and time required for IQRNs to adjust and adapt. Aligning values and beliefs with those that underpin Australian nursing practice (as articulated in mission statements, codes of practice, codes of conduct, models of care, policy documents and protocols guiding nursing practices) can be an area of personal conflict for IQRNs. IQRNs who have an understanding of the value system are better able to deliver safe, appropriate, person-centred nursing care. The ability of organisations and management to attract, recruit, support and ultimately retain the right person relies on effective transition to practice processes.

5.3 Learning the game

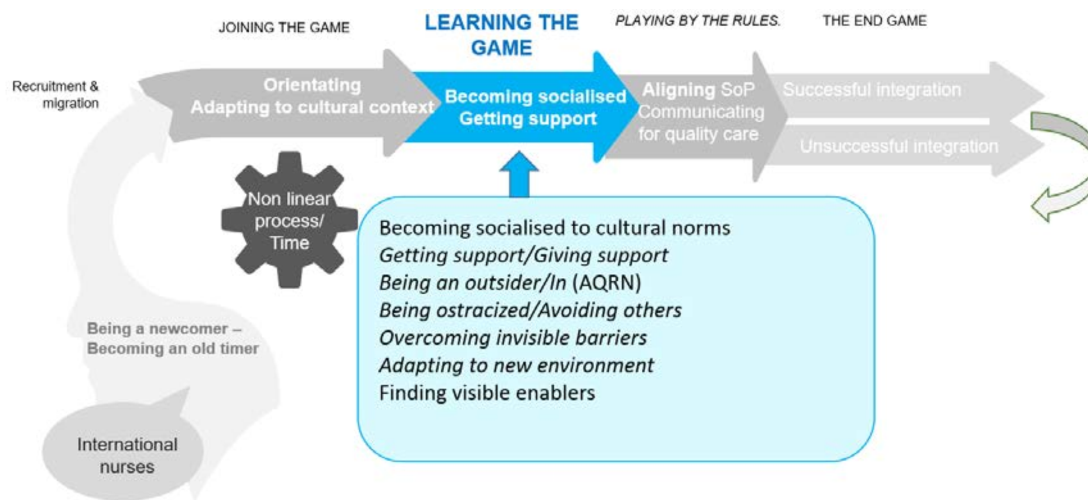

Figure 5.3. Learning the game

The following phase describes how IQRNs learn and acquire the knowledge to work in a new environment and make changes to their usual practice to 'fit in'. The context of the environment is instrumental in shaping the socialisation experience during the transitional adjustment phase. The processes used by IQRNs to achieve this state of equilibrium include seeking information, using diplomacy, asking for advice, attending in-services, building collegiate relationships and using interpersonal skills to facilitate social acquiescence in the workplace.

The workplace context is instrumental in supporting the adjustment of IQRNs and RNs to work together. IQRNs working in the Australian healthcare system make adjustments to their clinical practice to meet observed and expected standards of care provision. Equally, RNs in the existing workforce also learn from IQRNs' experiences of working in different health services. The social part of 'fitting in' and subsequent acceptance as a valued member of the team is achieved via processes such as exhibiting a friendly demeanour, sharing experiences, being collegial and respectful, demonstrating a willingness to learn, being a team player, adapting and accepting differences.

Adjusting to fulfil role expectations to become a trusted and valued team member who is able to provide safe, quality patient care takes time and requires a high level of interpersonal skills, insight, emergent confidence and a positive, reflexive attitude. The workplace environment is

dynamic and fluid and affects individuals' level of commitment, energy, time and ability to support individual and team resources. Emotional exhaustion can prevail. IQRNs from an NESB or CaLD background who require additional support, including with the English language, often network with colleagues with whom they share a common language, coupled with local RNs willing to support IQRNs' Australian English-language development.

Being able to communicate effectively in English is a concern shared by local and international nurses, fellow healthcare professionals, patients and their families. Addressing the English-language proficiency of bilingual nurses requires mutual collaboration to improve English-language mastery to communicate effectively. However, employing international nurses who speak a second or third language other than English is advantageous to patients from a similar background, culture or language. These nurses also have intimate knowledge of culturally sensitive practices for specific populations, which can enhance quality care.

When IQRNs migrate from a patriarchal healthcare system or one that follows a medical dominance model, additional support, education and adjustment to communication and clinical practice norms occurs. IQRNs who are accustomed to being directed by medical staff need reassurance and support to adjust their communication and practice to become confident to work autonomously and in collaborative, shared decision-making teams. RNs and IQRNs converse together to align expectations and identify strategies to enhance communication with patients and other healthcare professionals.

AQRNs voice concern to one another or a senior nurse if IQRNs repeatedly do not recognise limitations or do not ask for assistance. IQRNs do not seek help when they lack confidence, do not feel well supported, lack expertise in the clinical area of specialty or lack the interpersonal skills to be assertive. Avoidance behaviours occur when nurses do not want to work with IQRNs who are not up to speed or who are considered clinically incompetent; thus, they are effectively ostracised. This action creates tension within teams because additional time and effort is required to address concerns, assist and develop team members and ensure that patient safety is maintained.

Processes adopted by AQRNs to mitigate against adverse incidents include providing timely, constructive feedback, seeking authentic leadership from senior staff, providing education

and positive role modelling by staff, educators and nurse managers. Recruitment of the appropriate IQRN to the position and an appropriate mentor are vital to limit incidences of this nature. It is not necessarily the clinical skills that are essential; technical skills or routines are learnt relative to the specialty context. Each staff member requires interpersonal and social skills such as positive attitude, empathy, self-awareness and commitment to negotiate solutions to concerns raised between IQRNs and existing staff.

To assist IQRNs to 'fit in', nurse managers and clinical educators aim to 'make old timers out of new comers' who they feel are the right *fit* for the work area or have the right attitude, aptitude and ambition to learn (reflective of social capital). Catholic Health Australia promote how awareness of mission fit is important in the recruitment process to ensure recruited staff understand the philosophy of mission statements and how they are applied in private healthcare settings (Catholic Health Australia, 2018). Public sectors have human resource systems that vary depending on the individual organisation recruiting new staff. However, IQRNs require time and space to adjust and realign themselves to new ways. They must learn how to adapt or develop skills and ensure that their own cultural beliefs and values align with those of the Australian healthcare system. IQRNs may bring deep-rooted beliefs and assumptions to clinical practice that they must reflect on to ensure they are not imposing their values and beliefs on the person receiving care. IQRNs align values and professional identity during the process of professional socialisation. Re-forming professional identity reflects relatedness, motivation, enthusiasm and role modelling within context.

The prevention of sociocultural discord between local and international RNs relies on the adoption of strategies such as cultural humility and cultural tolerance. Cultural humility is expressed as an attitude via reflective practice and acceptance of difference, whereas cultural tolerance is conveyed when individuals respect values and beliefs that are different to their own while maintaining the self. The use of sociocultural skills, interpersonal skills and a graded introduction into the work environment in conjunction with self-efficacy has built resilience to meet dynamic and changing workforce demands.

Nurses use local knowledge of the cultural norms of the organisation or system to find 'workaround strategies' where they adjust their practice. Managing organisational constraints minimised risk and the need to *rescue* IQRNs in the course of clinical practice. Managing

hierarchical constraints meant that IQRNs had to raise red flags when practice expectations, workloads and orders from medical doctors did not align with their professional role or when there was a risk to patient safety. Responses included silent actions, diplomacy and direct responses to confrontation.

5.4 Playing by the rules

Figure 5.4. Playing by the rules

IQRNs adjust to new norms as they receive encouragement when they adapt to, conform and comply with the beliefs and behaviours of the work culture (i.e., *playing by the rules*) to become a member of the status quo. IQRNs develop an understanding of the cultural contexts related to effective therapeutic communication styles, alignment of values and beliefs, provision of quality nursing care, teamwork and cultural humility. Cultural humility is achieved by being reflexive, working collaboratively and embracing differences. *Playing by the rules* is linked to understanding sociopolitical undertones and nuances while learning the organisational politics of a workplace. For example, IQRNs recognise that they need to undertake additional activities to be accepted for promotion.

Navigating organisational politics and workplace culture encompasses learning unspoken rules of how things are done in a particular work environment. New IQRNs use diplomacy, circle and navigate on the outside, and circumvent speaking up or speaking negatively about concerns as they work out the hierarchy of 'who's who in the zoo'—that is, who speaks to who, who are the influencers and power players within the team, who are the champions,

who are the canaries in the unit and who they can trust. IQRNs on 457 visas often decide to stay under the radar to avoid confrontation and avoid drawing attention to any language or clinical skill discrepancy. They have a genuine fear of being seen as incompetent (despite working diligently), and they fear being deported or losing their job after any probationary period.

5.5 The end game

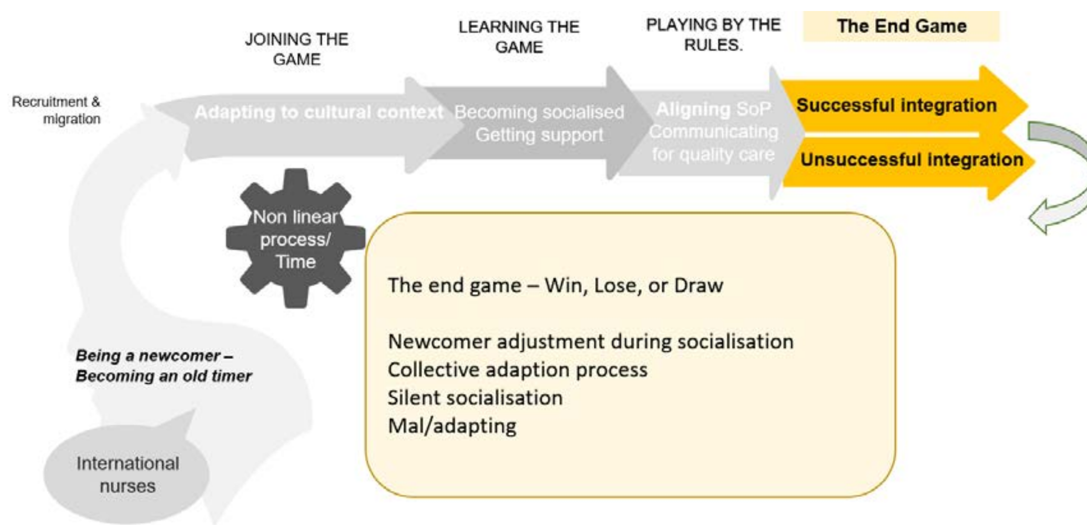

Figure 5.5. The end game

The end game describes integration as win, lose or draw. Recruitment, orientation and retention strategies are influenced by policy, fiscal considerations, management and human resource personnel to develop and maintain a nurse workforce to meet the demands of the organisation. Organisational politics and workplace culture can reflect the values and attitudes of the organisation and individuals, and they are not easily recognised or defined. Organisational politics requires an understanding of the systems or routines and interactions, connections or relationships within the work context that are contributory factors influencing how things are done. Overcoming invisible barriers—that is, the unwritten rules and unspoken words that influence actions and interactions within teams (e.g., undocumented ward routines)—enables nurses to fit in to the workplace culture and facilitates them becoming a valued and contributing member of the nursing team. If nurses are unable to infiltrate the culture, they may leave the work area, organisation or the nursing profession, which can adversely affect the organisation, work units, individual reputations and the profession.

5.5.1 The playing field: the 'maelstrom'

The context of the milieu, referred to as the 'playing field', influences the organisational socialisation process for IQRNs. Socialisation phases included orientating, observing, learning, adjusting and adapting to context, becoming socialised and aligning scope of practice. The phases were practiced by IQRNs and were associated with uncertainty, fear, insecurity and environmental constraints. Contextual factors include the role expectations of an RN, positive and negative work environments and factors that facilitate and also constrain the socialisation process. Context is crucial when explaining and describing socialisation processes. However, this study found that organisational socialisation strategies varied from facility to facility.

RNs who had previous negative experiences with nurses from a particular country (in particular, IQRNs from India, Southeast Asia and Africa) developed biases and stigmatising behaviours against these groups. This resulted in IQRNs adapting their own strategies to survive and succeed (e.g., influencing or aspiring to change others' perspectives of them, identifying as Asian rather than Indian, stepping up and taking on higher duties, or moving to another clinical area). While the focus on IQRNs' adaptive behaviours and organisational socialisation was often cited as being constrained by time, there was no link associated with a definitive timeframe to integrate into and adapt to a new work environment. Exemplars of IQRNs who have been employed for many years and are no longer newcomers demonstrates that socialisation is an ongoing dynamic process that often requires a self-initiated or proactive strategy to facilitate social integration into the team.

Figure 5.6. Successful integration

Retaining experienced staff is paramount to any organisation. However, negative work environments, incivility in the workplace and lack of appropriate resources to support staff affected participants' experience of transition, adaption and acculturation. The data showed that when integration is unsuccessful, individuals, work units, organisations and the profession are affected. A lack of consensus regarding the definition of quality patient care was identified as a contributing factor to adverse events, including death.

However, an unexpected finding related to international nurses who successfully integrated into and remained in the workforce, but did not progress in the nursing hierarchy. This was classified as a draw.

Figure 5.7. Unsuccessful integration

Storyline was a strategy used to achieve integration and aid in the presentation of the theory *playing the game*, which was presented to two focus groups to test and evaluate the theory. The criteria used to evaluate the theory are explicated in Chapter 7. Following the focus groups, some minor amendments were made to the theory.

5.6 GT: Playing the game

The following manuscript titled 'Playing the Game: A Grounded Theory of the Integration of International Nurses' has been submitted to an Australian nursing journal and accepted for publication. It was in press at the time of this thesis submission.

Publishing research findings is an important means of disseminating results to the nursing profession and sharing knowledge and experiences globally through publication.

Playing the Game: A Grounded Theory of the Integration of International Nurses

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Professor Melanie Birks

Professor Karen Francis

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Playing the game: A grounded theory of the integration of international nurses

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ABSTRACT

Background: Migration trends to Australia have seen an increase in international nurses, with twenty-nine percent of current registered nurses having received their first nursing qualification outside of Australia. The process international and local nurses navigate to enable successful integration into the Australian healthcare system is unclear.
Aim: To explore how international nurses and Australian nurses adapt to work together in the Australian healthcare system and to develop a theory that explains this process.
Methods: Grounded theory methodology was used. Concurrent data collection/generation and analysis of online-survey data (n = 186) and in-depth interviews (n = 15) was undertaken. Storyline was used as a technique of analysis to develop, construct and present the theory. Focus groups (n = 9 + 7) were conducted to confirm the relevance of the theory.
Findings: Nurses work together to enable successful integration of international nurses. Four phases underpin this adaptation to the cultural norms of the workplace: (i) *Joining the game*; (ii) *Learning the game*, (iii) *Playing by the rules*, and *(iv) The end game*. These phases comprise the grounded theory *Playing the game: Integration of internationally qualified registered nurses in the Australian healthcare system.*
Discussion: Additional orientation programs and collegiate support for international nurses were significant factors influencing successful adaption to the cultural context of the work environment. Defining the role and scope of practice of the registered nurse in the Australian context provided challenges.
Conclusion: Supportive colleagues were critical to successful integration and retention of experienced nurses irrespective of where nurses obtain their nursing qualification. Additional orientation programs for international nurses could improve the experience of nurses migrating to work in Australia.
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Summary of relevance

Issue
Nursing is a global workforce yet little is known about what processes impact on the integration of internationally qualified registered nurses into the Australian workforce.
What is Already Known?
Australia is a multicultural country reliant on experienced international registered nurses to meet shortfalls in specialty areas and geographic areas of need. International registered nurses make up approximately twenty-nine percent of the Australian registered nurse workforce.**?**

What this Paper Adds
Developing ongoing cultural responsiveness education for both local and international registered nurses aids successful integration, which is critical to retain and sustain the current and future nursing workforce in Australia.

1. Introduction

1.1. Background

In 2050 the world population is expected to exceed nine billion people, putting extraordinary pressure on already stretched global healthcare resources (Organisation for Economic Co-operation and Development, 2016). How healthcare is delivered to meet the needs of this expanding population varies across the globe. Health care systems, models of care, the role and responsibilities of the registered nurse, codes of conduct, scopes of practice, funding

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arrangements, definitions, philosophies, and cultural issues differ between countries worldwide.

The nursing profession makes up the majority of the healthcare workforce globally. Nurse migration regularly occurs from less developed to developed nations. Historically, nurses who migrated to Australia came from developed nations, predominately the UK, NZ and Canada, however since 2005 there has been an increase in nurses from India, Africa, the Philippines and China (Hawthorne, 2012). Furthermore, in 2016 nearly thirty percent of the Australian registered nurse (RN) workforce reported having received their first nursing qualification in a country other than Australia (Department of Health, 2017) meaning that Australian nurses often work in culturally diverse teams.

International nurses migrating to another country may be unfamiliar with some or all of the systems and processes in their new workplace (Murray, Bisht, Baru, & Pitchforth, 2012). The Australian nursing workforce is inclusive of people from over 150 different nationalities and cultures who deliver healthcare to a multicultural population (Hawthorne, 2014). International nurses need to understand the unique Australian context in order to integrate into the local healthcare system and effectively utilise their knowledge, skills and experience to contribute to safe culturally appropriate care (Xiao, Willis, & Jeffers, 2014).

Migrating to a new country and meeting requirements to practice as a RN involves complex processes. International nurses coming to Australia must meet strict nursing qualification criteria and demonstrate a high level of English language proficiency before being eligible to register with the Nursing and Midwifery Board of Australia (Nursing & Midwifery Board of Australia, 2016). Additional criteria such as completion of further education or a bridging program may be imposed before an international RN meets the requirements for registration (Nursing & Midwifery Board of Australia, 2016). Despite these measures, little is known about how international RNs and Australian qualified RNs adapt to work together in complex healthcare environments to provide quality nursing care to Australia's multicultural population. This study explored how local RNs and international RNs adapt to work cohesively together in the Australian healthcare system (AHCS). The result is a theory that explains this process.

1.2. Research question

What is the process by which international RNs and Australian qualified RNs adapt to work together in the Australian healthcare system?

2. Method

2.1. Study design

The aim of this study is to explore how international nurses and Australian nurses adapt to work together in the AHCS and to develop a theory that explains this process. A grounded theory design was employed to achieve this aim. Grounded theory is an appropriate approach if little is known about the substantive area of inquiry; where a conceptual theory is required; and when the research reveals a process intrinsic to the area being examined (Birks & Mills, 2015; Bryant & Charmaz, 2007). The essential grounded theory methods of initial coding and categorisation of data, concurrent data generation/data collection and analysis, writing memos, theoretical sampling, constant comparative analysis, theoretical sensitivity, intermediate coding, identifying a core category, advanced coding and theoretical integration as detailed by Birks and Mills (2015), p. 10) were used to generate an explanatory theory.

2.2. Participants

Participants were registered nurses from across Australia who have worked in the Australian healthcare system. In order to obtain rich data to inform the development of a theory that explained how they adapted to working together in the AHCS, data was sought from both internationally qualified registered nurses (IQRNs) and Australian qualified registered nurses (AQRNs). An IQRN is defined as a registered nurse who received their first nursing qualification to practice as a nurse in a country other than Australia. An AQRN is defined as a RN who received their first nursing qualification in Australia.

2.3. Data collection

Data were collected via survey, interview and focus groups. The survey was delivered online using the Survey Monkey platform. The online survey questions and an interview question guide were piloted and tested. A link to the anonymous survey titled *Working together: Internationally qualified registered nurses in the Australian healthcare system* was disseminated via Australian professional and industrial nursing organisations including the Australian College of Nursing and the Australian College of Critical Care Nurses. An information page was presented at the commencement of the survey and submission implied consent. The survey collected demographic data via multiple choice questions and data on the facilitators and barriers to integration via open text boxes. At the completion of the survey participants were able to volunteer to be considered for interview and/or a focus group. Any details provided for this purpose were not linked to their responses in the survey.

There was no obligation to participate in an interview, participation was voluntary and confidentiality was preserved. Participants who agreed to participate in an interview or focus group provided written consent. While some participants were known to the researcher, recruitment was based on anonymous completion of the online survey and their subsequent willingness to be involved. In-depth interviews were conducted in person or via information and communication technologies such as Skype, Zoom, or telephone, at a time and place convenient for the participant. Field notes were written immediately after each interview and focus group by the lead author. As grounded theory is an inductive methodology, participant recruitment was guided by the data analysis. This approach facilitated theoretical sampling, which was employed to ensure the collection of data that would inform the theory development. Theoretical sampling is "the process of identifying and pursuing clues that arise during analysis in a grounded theory study" (Birks & Mills, 2015, p. 68). Analytic memos were written during the research. Interviews varied between 48 min and 2-hour duration. Individual interview were audio-taped and transcribed by a professional transcription service. During advanced analysis, two focus groups were conducted to test the theory with an extended group of participants who agreed to be involved. Focus groups were held in a board room at the researcher's university campus. Attendance was either in person or via Zoom. Nil participants withdrew from the study.

2.4. Data analysis

Data were analyzed using grounded theory method of constant comparative data analysis through a systematic process of coding, categorization and theory development. Constant comparison refers to an analytical process used in grounded theory to compare data from all sources, including analytic memos, for coding and category development (Silverman, 2011). Consistent with the principles of grounded theory, data were collected and analysed concurrently. The survey remained open for the duration of the

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Table 1
Number of participants.

	Survey	Interview	Focus Group 1	Focus Group 2
AQRN	130	7	5	4
IQRN	56	8	4	3
Total	186	15	9	7

study enabling an abductive approach (Timmermans & Tavory, 2012) as the analysis moved between interview and survey data. Storyline is a method that can be used as an advanced coding technique (Birks & Mills, 2015). Consistent with grounded theory methods, data collection ceased when each of the categories were sufficiently explained and no new insights were gained. In this study storyline is employed to aid in the construction of a theory that described the phenomenon from the perspective of the participants. The storyline was tested for fit and relevance (Charmaz, 2014) with two focus groups. As a result of this testing, minor refinements were made to the final theory.

2.5. Ethical considerations

Ethics approval was received from the researchers' university Human Research Ethics Committee. Participation was voluntary, the online survey was anonymous, and confidentiality was preserved for interviews.

3. Results

A total of 217 RNs participated in the study. Responses were received from AQRNs and IQRNs (Table 1). Responses emanated from all Australian states and territories from RNs working in public, private or non-government sectors. Across the total sample the majority (88%) were female with 38 percent identifying as IQRNs.

The theory *Playing the game* was generated from this research. This theory, as presented in the following section, consists of four major categories: (i) *Joining the game*, (ii) *Learning the game*, (iii) *Playing by the rules*, and (iv) *The end game*. *Playing the game* is a metaphor that explains the process by which IQRNs integrate into the AHCS (Fig. 1). Metaphors were used to explain complex scenarios in understandable and relatable ways. A metaphor is one way to present abstract concepts so they can be understood (Yu, 1998). Metaphors can be used as a theoretical code that adds explanatory power to the final theory (Birks & Mills, 2011). *Playing the game* is an in vivo code that crystallised the process from the perspective of those that experienced the phenomenon.

The processes presented in Fig. 1 are nonlinear, with fluid movement between categories and over time. The key constructs in this grounded theory link organisational and professional socialisation contexts with the socio-cultural process of adaption.

4. Joining the game

Joining the game describes the process of orientating and adapting to the cultural context of the work environment from the IQRN and AQRN perspective. Prior to commencing work in Australia, international nurses navigated complex immigration and visa requirements. International nurses often underestimated the processes involved in gaining registration in Australia. Arriving in a foreign country, securing appropriate accommodation, accessing transport, settling into a new community and culture prior to commencing work in a new health care system was a major adjustment. International nurses who did not meet registration requirements completed a bridging program or an undergraduate nursing degree by an accredited provider in Australia. International nurses completing further study in Australia felt the experience assisted their transition into the AHCS and reduced environmental shock. International nurses who have English as a second or third language faced additional challenges. People made significant sacrifices to come and work in Australia so it was important the local workforce acknowledged the challenges international nurses face just *getting here* and *becoming registered*.

I do feel that our Australian trained nurses need to perhaps have access to some training or some education or have a conversation around so they can understand what an overseas qualified nurse is and what they have to do to get to Australia and the processes that they have to undertake to get in because it is quite difficult. (IQRN Focus group)

Health systems across the globe are not the same. Nursing is a global workforce but nurses are educated in local contexts, which can be very different to the healthcare system in Australia. A RN with experience working in several countries explains:

Internationally qualified nurses learn differently, they learn in a different system and they learn a different practice, so their model of care and how they do things is very different. . . . I think we need to understand their model of care, their practice. (AQRN Interview)

The majority of IQRNs indicated they received a generic orientation to the health service as for all new employees. However most did not receive a specific orientation individualised for an international nurse commencing work in the AHCS. While there were programs developed at some facilities to orientate international nurses to the Australian context, they were on an ad hoc basis. Orientation programs tailored to the specific needs of international nurses were not offered routinely nationwide. Nurses felt orientation was significant because the role and scope of nursing practice, models of health care and healthcare systems worldwide are not universal and therefore a specific orientation for IQRNs to the AHCS was warranted.

It was very challenging to have no [specific] orientation. I had never stepped inside Australia before. I was hired from outside the country so, um there is a lot more to it than that. (IQRN Focus Group)

IQRNs were supported into new work environments with supernumerary shifts and varying levels of peer or mentor support. IQRNs initially observed others from the periphery to determine what the norms of practice are and how they might position themselves in this new environment. IQRNs experienced environmental shock when the alignment of the expectations of their role was different to the actual reality of practice. As one IQRN from the UK stated:

I'm just thinking back about my own experience of coming here as a registered nurse having trained in England, and you would think that it would be very straight forward but it really wasn't. . . . it was really quite different because registered nurses in Australia did different things to registered nurses in England. They had different values, different expectations of them in their work and . . . getting used to that difference and trying to let go of my own stuff. (IQRN Focus Group)

Nurse unit managers (NUMs) confirmed recruitment and integration of international nurses remains a complex process. Australian nurse managers at a large regional hospital spoke of their experience:

It's multifactorial and so many different contexts. Integration depends on each individual person. Makes it very different to recruit people from different backgrounds into similar placements and similar experiences and training have been very different and their integration has been very different, and that can come back to the person or it can come back to the support of the environment that they have come into. (AQRN Focus group)

Furthermore, getting the right fit, right person, and right role was noted as instrumental to successful integration. NUMs disclosed international qualifications and experience on applicant's CVs were not a reliable indicator of skills or knowledge required for the position.

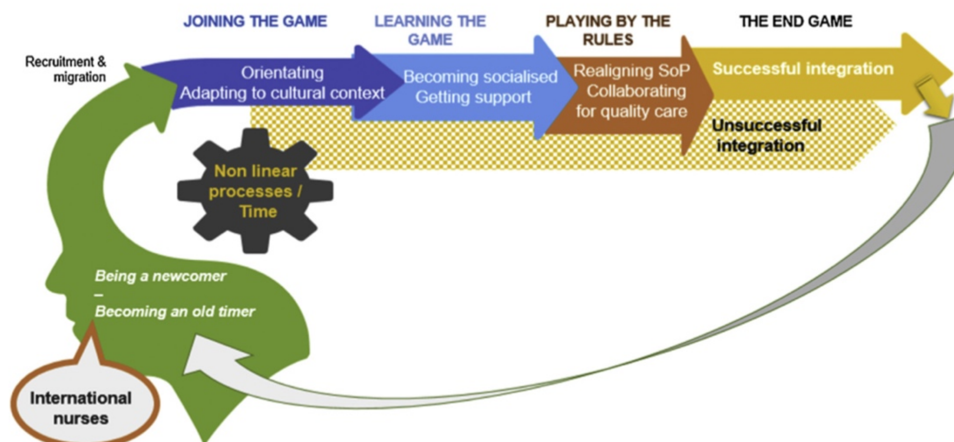

Fig. 1. Playing the game: A grounded theory of the integration of international nurses in the Australian healthcare system.

I see people who come from other areas [countries], and ... about CVs, they may be fantastic, have a wealth of experience and you bring them in to socialise them to the local environment [unit or ward] and it is very different and it is very difficult to then remove yourself from saying, 'next time we are not going to', and it is learning from it. (AQRN Focus group)

International nurses revealed adapting to the cultural context of the work environment involved realigning expectations of the RN role. IQRNs explained they had to assess what the RN role means in practice in the Australian context which often contrasted with previous experience. For example, IQRNs had clinical skills that they were not permitted to use and/or conversely required upskilling of skills or theoretical knowledge required to be able to work effectively and safely. Realigning expectations of the RN role in Australia was confronting and difficult for many IQRNs, but particularly for those with experience in senior roles and positions.

So I am educated and qualified to do this but no, no, you can't do that here.... I hear that from IQRNs as well, who come here from some of the other countries where they have really, really large scopes of practice for nursing.... I found a huge difference in what people from other counties think nursing means. (IQRN Interview)

... so when you come from a country that has a legislated scope of practice compared to a country where you have a scope of practice which is determined by the employer [in Australia] it is really challenging. (IQRN Focus Group)

A number of international nurses who completed an Australian nursing program confirmed undergraduate clinical placements reduced some of the environmental shock in comparison to that experienced by IQRNs when they first arrived. For example, an international nurse with English as a third language who completed an Australian nursing degree stated:

Yes it still was a little difficult due to the language barrier, but once you understood it okay to ask questions and ask for help it was easier. (IQRN Focus group)

Nurses seeing themselves as *being different* or having others perceive them to be different to themselves emerged as a theme from the data. AQRNs that had previous negative experiences working with a particular IQRN or group of IQRNs resulted in some being less tolerant to accepting new staff or reconsidered recruitment of the next cohort of people coming in from that particular country or background. Ultimately, the attitude and support that local RNs contribute to the transition process determined whether the IQRN was effective in *Joining the game* and therefore ultimately successfully integrated into the workplace.

5. Learning the game

The second phase, *learning the game*, described the process IQRNs undertake to become socialised to the cultural norms of the workplace. Understanding the nuances of how the game is played required insight, collaborations, and resources. Transitioning IQRNs safely took additional time and resources, particularly when onboarding significant numbers of IQRNs to meet organisational needs. Furthermore, the extent of support required was influenced by the experience and skill of both the support staff and the IQRNs. NUMs explained that socialisation was influenced by needs versus expectations. When IQRN capabilities did not meet expectations against which they were employed, existing nursing teams experienced additional strain.

There is the whole expectation of what we think someone is capable of, and we discover that maybe they're not, and where they need support. And then the fact that we actually need these people. So which one out balances the other? (AQRN Focus group)

IQRNs with English as a second language (ESL) or from a non-English speaking background (NESB) reported feeling nervous, intimidated, or embarrassed to ask or accept assistance even when it was offered. Many expressed fear speaking up would magnify any deficit in language, knowledge or skills and potentially affect their visa to stay and work in Australia. These nurses made a conscious decision to stay under the radar.

I identify coming from Asia because I do not want them to know I am from India ... they no like. (IQRN Interview)

Conversely the communication style of IQRNs who appeared aggressive, outspoken, or loud shifted the disposition on the ward and affected team dynamics.

People complain ... I can hear that Yankee accent before I even enter the ward, ugh, it just grates on your nerves. (AQRN Interview)

While some IQRNs confirmed they felt like they didn't belong, Australian RNs also argued they were rendered to feel like an outsider. This occurred when IQRNs from a NESB spoke their first language amongst themselves. AQRNs felt disrespected when international nurses did not speak English in their presence at work.

Australian RNs feeling a bit excluded now in some environments ... I am finding that what nurses are saying is that when they turn up for a shift there may be only one Australian RN on shift with the other 8 on shift being overseas trained nurses. (AQRN Focus group)

... there were 8 nurses on duty, 7 from the Philippines on a night shift in CCU [coronary care unit] where they spoke Filipino

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all night and I was the only Australian and couldn't understand what was being said. (AQRN Interview)

Conversely, speaking in a language other than English was accepted, if those present understood that language.

Visible enablers to aid *learning the game* identified as critical to work to their full potential and to be able to learn and grow in that role included additional orientation, peer support, and access to educational opportunities. IQRNs and AQRNs emphasised that all RNs need to have the emotional intelligence and social skills to work collaboratively.

6. Playing by the rules

To *Play by the rules* nurses used insight and emotional intelligence to adapt and re-align scope of practice to the context within which it is delivered. Communicating in English effectively, efficiently and collaboratively is a key process for providing safe, quality care. Facilitating cultural humility and cultural tolerance was recognised as necessary in an era of increasing cultural and linguistic diversity within the Australian health care workforce and across multicultural and diverse patient cohorts.

Local RNs stated while wanting to support and mentor IQRNs, inadequate resources challenged RNs' reserves over time. Local RNs conceded additional responsibility to support IQRNs at the bedside to meet patient needs impacted negatively on the existing workforce. Morale improved when RNs who could see the efforts of managers, educators or champions in the unit to upskill IQRNs. *Champions* is an in vivo code used by participants to describe RNs who were proactive in supporting new and existing staff. IQRNs were keen to learn and understand how things were done and attend in-services or education days. This was a consistent theme:

We are proactive in upskilling so their theory is updated to match their clinical skills. (AQRN Focus group)

In a way the great need in the department had a big impact on whether or not the staff were accepted. That is there was a lot of flexibility around what they saw as accepted levels of practice because you really needed someone to nurse this patient. (IQRN Interview)

Facilitating conversational competence in English was seen as a priority. Participants wanted to support nurses with ESL to improve and develop their English language proficiency. Concern also extended to difficulty understanding thick accents, and acknowledging different communication styles common to other cultures. Strategies to develop language competence and encourage engagement were met with resistance in several organisations. For example, a directive to only speak English at work, including in the tea room, had to be removed. This was irrespective of the intent of the initiative which was designed to support NESB nurses' confidence to communicate effectively and safely. Despite the resistance people were willing to assist IQRNs who made the effort to improve.

Some issues that have been raised in regards to accents, people speaking with deep thick accents and terms that others can't hear or understand . . .Every practitioner has the responsibility to ask what did you say and ask the IQRN to repeat what they have said but that does not happen every single time, so for me that is a risk to the nurses and to the patients which increases risk around communication. (IQRN Focus group)

IQRNs from Canada, UK, USA or NZ also expressed difficulty with Australian English, including spelling, pronunciations, and colloquialisms. An IQRN from Canada recalls:

I didn't think that for me that I would have any problems coming into the Australian context but actually I did. I just assumed it would be like Canada like I'm an experienced nurse and I speak English and I still speak the same language . . .. and language in Queensland is even different to that in Victoria so it really was quite a cultural shock for me. (IQRN Interview)

The shared goal for quality care provision was reached when nurses aligned their scope of practice, communicated for quality care and were *Playing by the rules* in the Australian context.

7. The end game: win, lose or draw

The final phase, *The end game*, referred to the outcomes of transitioning IQRNs into the AHCS. Successful transition (winning) was characterised by the retention of IQRNs as well as experienced AQRNs. IQRNs who integrated and adapted but were unhappy or reported barriers to progress in their career were signified as a draw. Those that did not stay in a position or left the profession were denoted as a loss.

A collective adaption process involved developing trusting relationships, cultivating positive work environments and being a team player. Realigning scope of practice and understanding what quality care looked like in the Australian context improved retention of experienced RNs, regardless of country of initial qualification.

. . . very conscious about not only being about the international nurses and what we need to do to help them integrate but it's about working with the Australian nurses to help them to understand the importance of positive integration and how they can achieve that. (IQRN Interview)

. . . you can actually be successfully integrated but still not have your trajectory for promotion normalised for say someone of your ability who is an Australian nurse, . . . unless you make particular steps to align yourself so that you are seen as someone who is as competent as any Australian trained nurse. (IQRN Interview)

Conversely, the corollaries of negative work environments include incidences of racism or discrimination, reduction in quality of care, adverse events including death and damaged reputations to individuals, departments, organisations, or the nursing profession. Ultimately, the financial cost of replacing experienced staff was reported as significant.

. . . there is something there to look at in terms of the registration and how we bring them [IQRN] in. If we don't do that well we set them up to fail and we set the Australian healthcare system up to fail and we end up with the problem with the patients, including death. So it becomes a big risk factor for us as a profession. (AQRN Focus group)

While it appears straightforward that diverse and multicultural teams must adjust to work harmoniously together in the provision of quality care, the evidence from this study suggests this process is complex, particularly in workplace environments that are dynamic. These workplaces are a maelstrom of activity and in a constant state of flux. Each shift brings change in the form of staffing levels, skill mix, workload, and patient acuity that impacts on individual nurses and the team. Environments or contexts in which nurses work are often subject to regular staffing changes that can disrupt the workplace culture that broadly refers to 'how things are done'. *The end game* reflects the outcome of processes RNs use to navigate to work together collaboratively in the provision of safe, quality care and highlight areas that require consideration to improve the transition, adaption and integration experience for all nurses.

8. Discussion

Prior to granting registration to practice as a RN in Australia, regulatory authorities assess internationally qualified applicants to ensure competence to practice (Stanhope-Goodman, Brenda, & Nordstrom, 2014). Despite these measures this study found that IQRNs face challenges to practice confidently and safely in the Australian context. An important issue emerging from these findings

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is that there was uncertainty around the role and scope of practice of a RN. Scope of practice is not well defined even though guidelines and standards exist (Birks, Davis, Smithson, & Cant, 2016). In addition, although all IQRNs must demonstrate English language skills suitable for registration (NMBA, 2018), communicating in English and understanding colloquial language create additional hurdles for IQRNs, particularly those with English as a second or third language. Practice, culture and language differences persist as significant issues for IQRNs integrating into foreign healthcare systems. These findings are consistent with those described by Stankiewicz and O'Connor (2014).

The organisational culture encompasses the values, beliefs and principles of an organisation, while the workplace culture is a specific subculture within an organisation such as a ward, unit, department, or a professional group such as nursing (Braithwaite, Herkes, Ludlow, Lamprell, & Testa, 2017). Findings in the present study suggest workplace cultures are influenced by individuals' perceptions, attitudes, and ability to accommodate changing conditions. New staff, including IQRNs entering a health care workplace, are challenged to understand the culture, negotiate their role/s and responsibilities, and establish a place within the existing context (Chun Tie, Birks, & Mills, 2018).

The theory of *Playing the game* indicates that integration into the workplace involves learning the norms of the setting as well as adapting and modifying knowledge and skills in order to meet organisational and professional expectations. Consistent with earlier research, workplaces that invest in staff are more likely to provide supportive environments that nurture existing and new staff (Moradi et al., 2017) including IQRNs. When new staff are not integrated successfully, outcomes for individual team members and the overall team dynamic can be negative (Ho & Chiang, 2015). The findings from this present study suggest that experienced RNs who are unable to provide adequate support for IQRNs to ensure quality care become disenfranchised and may consider leaving the profession. This situation also presents a risk to the reputations of individual RNs, organisations and/or the nursing profession more broadly.

Nurses are expected to work collaboratively with the provision of safe, quality, culturally congruent care (Queensland Government, 2012; Ong-Flaherty, 2015). The theory of *Playing the game* emphasises that effective integration of IQRNs into health services requires mutual accommodation and reframing by both local and international nurses. IQRNs move through the phases of transition and adaption over time to become integrated. The theory also established that the dynamic nature of adaption and transition to practice is not linear. IQRNs move between becoming socialised to the cultural norms of the workplace, through to aligning scope of practice, yet not all factors have equal salience.

Regulatory authorities, employing organisations, and management share responsibility for the safe transition of new staff. The findings of this study suggest that nurse leaders and nurse managers are in a position to connect individuals within teams, reconcile differences, assist nurses to adapt and assent to the changing landscape, and mitigate any potential for adverse team dynamics. Champions at the coalface are best positioned to optimise positive change. Developing suitable resources is an essential strategy in providing information, education and appropriate support measures.

Support measures identified in this research include provision of additional tailored orientation programs for IQRNs that facilitate a shared understanding of the value and beliefs of the organisation, the organisational structure, and local policy and procedures. Establishing a mutual understanding of the expectations of the RN role is imperative in avoiding misunderstandings. Information on the responsibilities, ethical conduct and professional behaviours of a RN, cultural awareness, and exemplars of colloquial language should be offered. Findings of this study suggest that the provision of authentic, collegial support including sociocultural factors of collaboration, trust and motivation, prove most effective in supporting new IQRNs into the workplace.

This research found that formal and informal strategies initiated through mutual discourse provide opportunities for all staff to connect with each other; through sharing of professional experiences, stories, and the cultural knowledge IQRNs bring. While the theory *Playing the game* does not explain the relationship between role clarity and work satisfaction, fostering a shared understanding of role expectations of the registered nurse in Australia using real life scenarios is one strategy IQRNs acknowledge as being beneficial. Such strategies will guide cultural competence education, promote skill acquisition, facilitate approaches to creating positive team dynamics, and ultimately improve nurse retention.

8.1. Recommendations

This study has shown the important role that orientation plays in ensuring safe, quality health care for patients. While orientation programs for IQRNs have been suggested (Fouché, Bartley, & Brenton, 2014; Healee & Inada, 2016; Holmes & Grech, 2014; McGrath, 2004; Philip, Elizabeth, & Woodward-Kron, 2015) introduction of a national orientation programs for IQRNs is necessary. Regulators and organisations share responsibility for IQRNs to have access to information and appropriate orientation necessary to ensure competence to practice in the AHCS. Tailored orientation programs for IQRNs are required in addition to the generic orientation all new staff receive. These programs should be developed and delivered by employing agencies and include context and culture (workplace, practice and community) specific information. Topics for inclusion in these programs could include an overview of the AHCS, information on health care delivery in Australia, the public and private health system, Medicare, person centered care, cultural competency, inter-professional communication and models of collaborative decision making with the patient or consumer.

To address the issue of English language competency and proficiency concerns, the introduction of free or subsidised context-specific language lessons to improve spoken and written communication should be considered. The responsibility for delivering initiatives to improve IQRNs English language skills must be a shared responsibility between recruitment agencies, the regulatory authority and employing agencies.

To aid integration, IQRNs should be allocated a mentor that has experience with or as an international nurse and understands that the orientation and transition of new IQRNs requires special knowledge and skills. RNs who mentor IQRNs, along with nurse mangers, clinical nurse consultants and clinical educators, may need additional information and education to understand how to better support IQRNs into the organisation and work unit safely and in a timely manner.

Further research is required to determine the impact of ineffective integration on the confidence, reputation and retention of both AQRNs and IQRNs. Research may also examine additional English language programs to determine their efficacy. Furthermore, the development of standards, indicators and benchmarks to test the effectiveness of additional orientation programs for IQRN should be undertaken.

8.2. Limitations

Recruitment via nursing organisations may limit the pool of potential participants however participants were received from all Australian states and territories, across public and private sectors and across a broad range of practice areas. Only RNs who felt confident in their experiences or language ability may have chosen to

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respond. Consistent with the intent of substantive grounded theory research, the results from this grounded theory are not generalizable, however there are learnings from this work that may inform other health professions and contexts.

9. Conclusion

The grounded theory *Playing the game* offers a new way to conceptualize the process of integration of international nurses into a foreign healthcare system. The study has shown that IQRNs move through phases of transition and adaption iteratively to enable integration to occur. The findings of this study add to our understanding of how fostering inclusive environments that acknowledge and accommodate differences can facilitate successful integration of IQRNs into foreign healthcare systems. This study highlighted the strengths and value mutual accommodation of nurses in the nursing workforce brings and the strategies required to facilitate positive team dynamics within a culturally diverse nursing workforce. Cultural diversity within the nursing workforce can realise untapped dividends that build robust, reflexive and collegiate nursing teams that deliver culturally responsive quality care. This work has served to inform the development of strategies that will improve retention of experienced local RNs and IQRNs thus maintaining and sustaining a workforce that is equipped to provide safe, quality nursing care for all Australian citizens.

Disclosures

Ethics approval for research involving human subjects was received from an Australian University Human Research Ethics Committee. Research conformed to the S̈tatement on Human Experimentation̈by the National Health and Medical Research Council of Australia.

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5.7 Chapter summary

This chapter presented the integrated GT *playing the game* using the strategy of storyline. Storyline is used to achieve integration and aid in the presentation of the theory. Metaphors that are conceptual in nature were selected to present the complex processes that were constructed from the data. International nurses and Australian nurses move through phases iteratively to enable integration and adaption to occur. The published manuscript (in press) aims to present the findings from this study to a broad audience. The next chapter links existing theories to the findings of this study and situates these within the extant literature.

Chapter 6: Discussion

Esprit de corps

6.1 Introduction

This chapter extends the GT *playing the game* by discussing the key findings of this study and situating these findings within existing knowledge. The significance of the substantive theory *playing the game* constructed from this study is discussed in this chapter. The theory is situated within the socialisation, organisational and psychological literature in relation to the metaphors *joining the game*, *learning the game*, *playing by the rules* and *the end game*.

In this study, *playing the game* is a metaphor that explains the process of integration from the perspective of those who experience the phenomenon. *Playing the game* was an in vivo code that crystallised the process of integration from the perspective of AQRNs and IQRNs who work in the Australian healthcare system. Significant issues relevant to each phase of this process will be discussed in the context of the existing literature.

6.2 Playing the game

As discussed in Chapter 3, theoretical coding in GT is used during advanced analysis to add explanatory power and position the proposed theory in the context of what is already known (Birks & Mills, 2015; Thornberg & Charmaz, 2014). Metaphors may be used as theoretical codes when they have relevance and fit (Birks & Mills, 2011). The GT *playing the game*, as presented in the previous chapter and illustrated in Figure 6.1, is a metaphor that explains the process by which AQRNs and IQRNs adapt to working together in the Australian healthcare system.

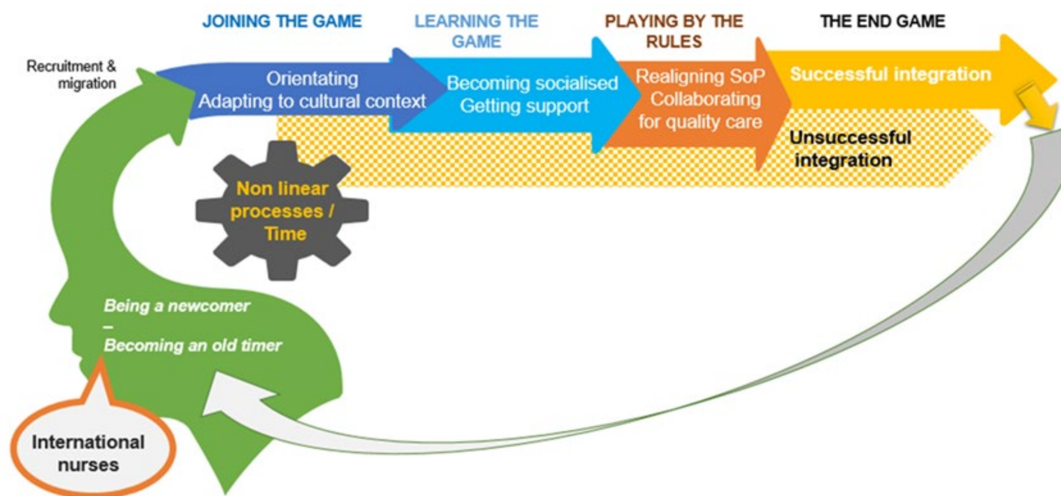

Figure 6.1. Playing the game: a GT of the integration of international nurses in the Australian healthcare system

Participants in this study who contributed to the focus groups instinctively understood the metaphor *playing the game*, which captured the professional, social and psychological aspects of *joining the game*, *learning the game* and *playing by the rules* to successfully integrate into a new healthcare system and work environment. Similar to the iterative processes in GT, and reflective of the dynamic environments in which they worked, this study found that nurses progress through the phases outlined in the theory *playing the game* (see Figure 6.1) in a fluid and recursive manner.

6.3 Joining the game

Factors worthy of discussion in relation to *joining the game* include the importance of *orientation*, issues of *language and communication*, the *transition* process and the existence of *unwritten rules.*

6.3.1 Orientation

Orientation plays a crucial role for all health professionals when they migrate to work in a foreign country to ensure they have the information required to deliver safe, quality healthcare for patients, clients and consumers of health services (Boylston & Burnett, 2010; Curran, Hollett, Hann, & Bradbury, 2008; Holmes & Grech, 2014; Sherwood & Shaffer, 2014). Regulatory authorities and employers share responsibility for the safe transition of health professionals into the healthcare workforce (Australian and New Zealand Council of Chief

Nursing and Midwifery Officers, 2015; COAG Health Council, 2017; NMBA, 2018d). For this reason, and as this study found, health professionals should receive specific and detailed information about their professional role, scope of practice, legislative and professional responsibilities, and national standards and codes, as well as the mission statements, policies and procedures that guide professional practice in the local context of employing organisations. The results of this study determined that IQRNs require a specific orientation and information tailored to their needs to understand how healthcare is to be delivered in Australia. However, while the literature reports on programs that support the transition of new graduate nurses or newly qualified HCPs, evidence on the transition of experienced IQRNs remains poorly explored (Harrison, 2018; Kinghorn, Halcomb, Froggatt, & Thomas, 2017).

Orientating and adapting to the cultural context of the work environment occurs for people commencing work in a new position or organisation (Korte, 2007). Undertaking an orientation program is an important process for any nurse commencing work in a new position or in a new facility or organisation (Harrison, 2018). Orientation programs are often provided during the on-boarding process for new staff members commencing work in a healthcare organisation (Bauer & Erdogan, 2011; Friday, Zoller, Hollerbach, Jones, & Knofczynski, 2015), with specific orientation programs provided for nurses (Brook, Aitken, Webb, MacLaren, & Salmon, 2018; Edwards, Hawker, Carrier, & Rees, 2015; Kurnat-Thoma, Ganger, Peterson, & Channell, 2017). This study established that IQRNs commencing work in Australia attend the same orientation programs as local RNs; however, generic orientation programs do not provide additional information required by IQRNs regarding the Australian healthcare system, expectations of the RN role in Australia, demographics of the Australian population, legal obligations and the scope of practice of the RN in local contexts. There is no registration requirement for IQRNs to undertake a specific local orientation program tailored to their needs. In contrast, International Medical Graduates (IMGs) receive specific programs and long-term support to transition into the Australian healthcare system, culminating in a work performance report after their first three months of supervised practice (AHPRA, 2016; McGrath & Henderson, 2009). Similarly, Mason's (2013, p. 267) review of the Australian Government's health workforce programs states that while there is no legislative obligation for new nursing graduates to undertake a transition to practice program:

> Most newly graduated employees will need to be supported and mentored by organisational structures and day-to-day managers, to assist these new staff to adjust to the realities of the workforce. As is the case for other professions, nurses and midwives need well-structured and well-resourced recruitment, induction and orientation programs on commencement of their employment.

Organisations employing IQRNs had an expectation that they should meet strict educational qualification criteria, English-language requirements, criminal history checks and any additional requirements if migrating from certain countries. Additional prerequisites expected by some employing agencies included successful completion of an approved bridging program or an approved accredited nursing program of study at a tertiary institution in Australia (ACN, 2016; AHPRA, 2018a). Employers' expectations were that IQRNs should have the knowledge required and/or experience from these programs to work independently as an RN in Australia. The results of this study indicate that this is a naïve expectation and that IQRNs need additional orientation to the Australian context, irrespective of the country in which they obtained their first nursing qualification or their experience and skills. Kawi and Xu (2009, p. 174) find that inadequate orientation is a significant barrier to the successful integration of internationally educated nurses into foreign healthcare services and recommend an 'evidence-informed programme to facilitate the successful adjustment of INs [international nurses] to their new work environments'. Jose (2011) examines the subjective perspectives of internationally educated nurses in US hospitals and identifies that improvements in orientation and transition programs are necessary. Similarly, an integrative review by Zizzo and Xu (2009) finds that the content and length of orientation programs is deemed inadequate by internationally educated nurses in most orientation programs in the US. These studies support the present study's finding that additional specific orientation programs tailored for IQRNs are needed.

IQRNs in this study offered that despite being experienced RNs, they did not feel that they should be expected to 'hit the ground running' without additional information and support. Phillips, Kenny, Esterman and Smith's (2014, p. 106) study of new graduate nurses finds:

> Transition from student to new graduate nurse is challenging and stressful, with health care providers expecting graduates to 'hit the ground running'. The reality is that most graduates experience role adjustment difficulties and require support from senior colleagues within health care organisations.

The participants in this study identified that an individualised orientation program in the Australian healthcare system is vital but not routinely offered. They revealed that most attend generic orientation programs that are not tailored to IQRNs. They recommended that topics in orientation programs for IQRNs should include the expectations of the RN role in Australia, scope of RN practice, regulatory standards and policy, multicultural populations served by nurses (including Aboriginal and Torres Strait Islander peoples), areas of practice and the diversity of geographic regions of Australia, including regional, rural and remote settings.

6.3.2 Language and communication

Effective communication is a significant requisite for nursing competence and is integral to patient safety and the success of any work environment (NMBA, 2016b, 2018b). The principal concern of AQRNs was how IQRNs are able to receive Australian nursing registration when their English-language proficiency is considered inadequate for safe communication between RNs, other HCPs, patients and their significant others. This concern raised queries about the AHPRA and NMBA's assessment of English-language skills registration standard and whether they are adequate. Despite completing approved courses or programs at considerable expense (A$12,000–$15,000 for a 12-week program), some IQRNs still struggled with English-language expression and fluency to communicate effectively and efficiently with the healthcare teams providing care to patients. This was compounded when the IQRNs were sent to rural or remote areas with a larger Australian Indigenous population and less support from other RNs.

An interesting finding from this study was the importance that IQRNs placed on AQRNs having an understanding of the difficulties they faced. This study established that IQRNs with ESL wanted consideration from local nurses that additional language support was needed. Similarly, Philip et al. (2018) conclude that 'educating their nursing colleagues about the actual experiences of OQNs [overseas qualified nurses] and their concerns is as a way of facilitating more empathic relationships and hence better communication' (p. 8). Further, Philip et al.

(2018) investigate the ‘complex learning needs relating to clinical communication’ (p. 8) and find that a mentoring partnership is an effective strategy. With the growing multicultural population, and hence workforce, in Australia, a well-prepared and empowered CaLD group of nurses can cater to the specific intercultural communication needs of diverse patients to create enhanced care outcomes.

Evidence from this research suggested that nurses were frustrated by the lack of English proficiency in new cohorts of IQRNs. Even IQRNs from English-speaking countries such as Canada, the US, NZ and the UK used accents and colloquialisms that created additional and unexpected challenges for IQRNs, AQRNs and patients. For those from an NESB, it takes time to understand the intended meaning of words, translate their own language into Australian English as the lingua franca and understand the professional language used in healthcare settings in Australia, including common abbreviations, acronyms and medical terminology.

This study also found that therapeutic communication styles vary across cultures and countries worldwide. A similar conclusion was reached for IMGs adapting to UK communication styles (Cross & Smalldridge, 2011), IQRNs in Norway (Viken, Solum, & Lyberg, 2018) and variance in Japanese nurses’ communication styles (Omura, Maguire, Levett-Jones, & Stone, 2017; Omura, Stone, & Levett-Jones, 2018a, 2018b; Omura, Stone, Maguire, & Levett-Jones, 2018). Sarangi (2017) defines variation in communication style in multicultural settings as ‘communicative vulnerability’, whereby vulnerability is described as ‘a deficit or lack of equipoise in linguistic, communicative, institutional and socio-cultural terms’ (p. 242). Learning the nuances of an additional language is a continuing process that incorporates social and cultural aspects of the local culture and the profession (Lum, Dowedoff, Badley, Kerekes, & Valeo, 2015).

As the findings in this study illustrate, all nurses need to be receptive to diverse communication styles and be willing to work towards developing a mutual understanding. Nurses use high-level communication skills when interacting with patients and clients (Brunton & Cook, 2018; Crawford, Candlin, & Roger, 2017; Crawford, Roger, & Candlin, 2018; Omura et al., 2017; Peddle et al., 2018; Philip et al., 2018). However, this study reveals that AQRNs are less tolerant and understanding of fellow healthcare colleagues because of the additional time they need to understand or interpret foreign accents. The study found that,

at times, there was negativity by AQRNs towards IQRNs who were not proficient in the English language. This was reported to place an increased burden on AQRNs by adding to their workload because of the additional time it takes to interpret what is said or to ensure that what is said is understood. Choi, Pang, Cheung and Wong (2011) confirm that co-worker relationships are imperative to work satisfaction and retention. Increased workloads negatively affect relationships with co-workers (Mavromaras et al., 2017).

The findings of this research suggest that we need to move beyond the narrow linguistic focus and adopt approaches to support best practice. A dialogic approach based on the theory of dialogism developed from the work of George Herbert Mead and Mikhail Bakhtin (Hall, Vitanova, & Marchenkova, 2005; White, 2009) refers to a way of analysing communication that allows for the construction and appropriation of new meanings and to expand the capacity to cross-cultural borders. This study found that improving conversational English occurs through socialisation in practice or social settings via formal and informal means. It found that, as language is socially, culturally and historically constructed, local variations in vocabulary, including colloquialisms, occur throughout the Australian states and territories. Situated learning occurs as IQRNs, including IQRNs with ESL, construct new knowledge and understanding to improve confidence and gain membership to the local discourse. Having ESL means that many IQRNs experience dual socialisation. Studies have shown that people from NESBs experience specific language and cultural challenges, indicating they experience a linguistic disadvantage (Roberts, 2010). IQRNs may retain cultural allegiance to other IQRNs in their situation or subgroup while navigating or adapting to the linguistic and cultural orientation of their new work context.

6.3.3 Transition

This study determined that following recruitment, registration and migration, IQRNs adapt and adjust to their transition into the work environment. Transition occurs through processes whereby IQRNs integrate into the social networks that make up the workplace. These findings concur with Välipakka (2013, p. 2), who suggests that the cultural and educational background of the newcomer needs to be considered when raising cultural awareness at the workplace 'to improve international nurses' work orientation'. Similar to the findings in this study, Välipakka (2013) finds that not all newcomers are inexperienced. Socialisation and

assimilation research literature commonly refers to newcomers as 'entry-level employees with limited power' (Scott & Myers, 2010, p. 80). This is in contrast to the findings of this study with respect to IQRNs who arrive with a great deal of knowledge, skills and experience. The findings from this study concur with the statement that IQRNs are principally experienced professionals.

As discussed, much of the extant literature reports on the value and merit of support programs for the transition of new graduate nurses (Ankers, Barton, & Parry, 2018; Harrison, 2018; Rush, Adamack, Gordon, Lilly, & Janke, 2012), IMGs (Zulla, Baerlocher, & Verma, 2008) and newly qualified HCPs (Covell, Neiterman, & Bourgeault, 2016). However, evidence on the transition process of experienced RNs remains poorly explored (Kinghorn et al., 2017). Further, evidence of IQRNs' transition experiences from the local workforce perspective is lacking. Similarly, most expatriate socialisation studies focus on the proactive behaviours of emigrants. Fu, Hsu, Shaffer and Ren's (2017) longitudinal study examines the organisational socialisation tactics from the local host perspective and finds that they occur over time. The present study also found that socialisation is an ongoing process that continues to influence performance and commitment to stay, even after IQRNs are no longer newcomers or are long-term employees. The findings from this study determined that the local workforce is instrumental in assisting new staff members to transition safely into the work culture as they learn how to *join the game*. However, equally, it is the support of management for local staff that affects their decision to stay or leave.

The findings from this study present a case for mentors, peers and clinical educators who assist with transitioning IQRNs to have specific skills and expertise in orientating and transitioning IQRNs from a range of countries, educational backgrounds, languages and nursing experience garnered from working with IQRNs or from working in one or more foreign healthcare systems. IQRNs come with a range of philosophies of nursing. In addition, some evidence from this study suggests that teamwork can be complicated by the cultural nuances related to caste systems that affect how international nurses can best work together in Australia while maintaining their individual customs and beliefs. This study found that nurses from India have a complex caste system. This factor is relevant because IQRNs who migrate to Australia to work with other RNs from India have to navigate the cultural nuances of the caste system. This situation becomes problematic for those involved if one RN has a higher

position in nursing but is of a lower caste. This will continue in the future because India announced new laws, commencing 12 January 2019, to extend caste-based quotas in higher education (Niazi, 2019). However, this study established that cultural humility was found to be a key attribute in enabling meaningful support to occur.

Australia is a multicultural country, yet diversity is still not considered mainstream. Diversity in the IQRN workforce contributes to the multicultural nursing workforce, bringing a wealth of additional experience and nursing knowledge to practice. The findings from this study found that peers, mentors and clinical educators of IQRNs need additional skills to assist IQRNs and the local workforce to transition, adapt and align expectations of nursing practice in the Australian context to meet the expectations of patients, clients, consumers and communities and deliver safe, quality nursing care. The study found that major hurdles include English-language proficiency, understanding the role of the RN and scope of practice in the Australian context, lack of cultural humility and tolerance, and not having a shared understanding of the professional values that underpin quality nursing practice in the Australian healthcare system.

6.3.4 Unwritten rules

While concrete processes and visible enablers illustrated in the GT *playing the game* assist IQRNs and local RNs to work cohesively and collaboratively, this study confirmed that it was often the silent and unwritten aspects of work routines and practice expectations that created the most ambiguity and concern for IQRNs. This was also true and representative of the experiences of local RNs with IQRNs in relation to IQRNs' unspoken values and beliefs around what constitutes professional nursing practice. Orientation programs commonly cover the basic introductory materials necessary to commence work in an organisation (Edwards, Hawker, Carrier, & Rees, 2015; Holmes & Grech, 2014). The values of the organisation are described and are contained in mission statements, policies and other documents (Kirkpatrick, 2009, 2017; Kurnat-Thoma et al., 2017). Nevertheless, this study identified that once IQRNs commence work in the clinical area, there is a realisation that a second set of values exists that are more difficult to recognise and understand. These values, which are not contained in any policies or documents, are the unwritten, implied, yet often unspoken rules.

An exemplar from this study is ward routines, which are understood and known to local RNs in the work unit who are exposed to them, but not obvious or clear to a recently employed IQRN, which is reflective of comments made by Hunt (2004, p. 108):

> Policies, procedures, protocols, codes of conduct and so on may have some formative influence, but there are powerful and pervasive features that are invisible and silent. These features are a shifting matrix of unquestioned and largely unconscious habits, routines, reflexes, attitudes and defences that emerge from the structure and functions of the health care organization. I am speaking of organizational *culture* … Newcomers are inducted, unwittingly one might say, into the prevailing attitudes of the organization. They gradually adopt certain attitudes and values (and omissions and silences) and, after a while, they get to know 'how things work around here'. Some questions they may ask 'legitimately' and openly, some they may ask only certain people and only in a certain way at a certain time, and some questions they may not ask in any way at any time. Very often the 'legitimate' kind are trivial questions and the unaskable ones are the most important. The really important questions are often very basic, but someone who asks them is, in some situations, likely to be branded as 'naïve' (or, if persistent, a 'troublemaker') because apparently they have not learned how to play the game of the organization.

It is necessary for IQRNs to understand the unwritten rules to ascertain how to fit in while learning how to *play the game*. For IQRNs in this study, one of the most difficult processes in learning how to play the game is developing an understanding of expectations of practice and ward or unit routines. IQRNs need to know the inherent expectations for practice, which are understood by those in the know, but to a large extent are an unstated requirement.

This finding was complex because many things are known by the knower but not articulated in documents or policies. These are the unwritten rules of diplomacy, where those with a high level of emotional intelligence recognise how to *play the game* and work out who '*the influencers*', the '*canaries in the unit*' and the '*champions*' are, as illustrated in the in vivo codes derived from this study. Emotional intelligence refers to the ability to recognise, understand and manage our own emotions and those of others in an adaptive or effective way (Almost et al., 2016; Foster et al., 2017). Every work milieu has political undertones that

are not always obvious or conspicuous to a newcomer. IQRNs observe from the periphery as they gain confidence and learn how to *play the game.* IQRNs use emotional intelligence, to understand what they need to do to survive (initially) and then thrive. AQRNs observe IQRNs to evaluate what support or resources may be needed to ensure the IQRNs can be a successful fit for the position or, in turn, what the local staff can learn from the experience and knowledge of IQRNs' former practice.

6.4 Learning the game

Learning the game was influenced by organisational socialisation, social capital and professional socialisation. These factors influence, and are influenced by, the formation of professional identity and concepts of leadership, professionalism and diversity.

6.4.1 Organisational socialisation

Results from this study found that the provision of quality nursing care requires a balance between resources and supports, including the right circumstances in terms of individual IQRNs' capacity and capability, workload, environment (resources and supports) and workplace culture. The significance of these findings is the association between organisational socialisation and workplace culture that affects staff turnover, intent to stay or leave, and patient experience. Findings from this study support those of Braithwaite, Herkes, Ludlow, Testa and Lamprell (2017), who find 'a consistent association between organisational and workplace culture, and patient outcomes' (p. 1).

Organisational socialisation refers to the processes used to learn the social knowledge and skills required to work in a new role in an organisation. Equally salient, it includes the learning of a cultural perspective, which reflects a nuanced understanding of the work environment over time. Mannion and Davies (2018, p. 4) acknowledge the complexity of organisational culture in healthcare:

> Too often the term culture is used as a metaphor for something the organisation is thought to have. But acknowledging that culture is a complex construct can allow more judicious application of the concept. Paying greater attention to the multilayered and multifaceted complexity underlying the term—and recognising that many and varied

> cultural subgroups make up our healthcare organisations—opens new avenues for understanding the deeply social and discursive nature of complex organisations.

The participants involved in this study included IQRNs and AQRNs who were employed across a broad range of sectors in diverse roles across each Australian state and territory. Many had worked in acute healthcare facilities, including hospitals. Mannion and Davies (2018) describe hospitals as 'a dynamic cultural mosaic made up of multiple, complex, and overlapping subgroups with variably shared assumptions, values, beliefs, and behaviours [cultures]' (p. 2). The overlapping subgroups Mannion and Davies (2018) refer to are inclusive of nursing, medical practitioners and AH professionals. This study found that the nursing workforce also has subgroups with shared beliefs and values, which are reflective of the diversity within the Australian nursing workforce, as previously noted.

The strategies that experienced IQRNs use to adjust to new health systems and work environments are different relative to new graduate nurses. A study by Cooper-Thomas, Anderson and Cash (2012) confirms that organisational tactics are less effective for experienced newcomers. Therefore, organisations need to be aware of the distinctive socialisation process that IQRNs undertake and consider an international context for the management of socialisation and orientation programs. Likewise, studies situated in the socialisation literature reiterate how globalisation means that organisations need 'an international context for the management of organizational socialization' programs (Feldman, 1997, p. 1).

Saks and Gruman (2011, p. 14) offer a different perspective and suggest that research and practice on organisational socialisation should move towards one centred on positive organisational behaviour:

> demonstrate how the prevailing perspectives of organizational socialization are based on a cognitive-learning process that emphasizes information and knowledge acquisition … and argue that socialization processes should be designed to develop the psychological capital of newcomers … and describe four broad socialization resources that can be used to develop newcomers' self-efficacy, hope, optimism, and resilience.

These four capabilities overlap and support the findings from this study, which found that social and psychological social capital is a resource that individuals use within the social milieu and is a significant indicator of successful integration. *Self-efficacy* was demonstrated in nurses having self-belief and an optimistic personality, *hope* was demonstrated in having confidence, *optimism* through being positive and enthusiastic, and *resilience* was demonstrated in the strength, flexibility and resistance displayed by IQRNs and AQRNs working together. Social capital is recognised as a multi-dimensional concept and will be discussed relative to the findings of this study in the next section.

6.4.2 Social capital

Social capital is a well-known concept that explores the value of social networks (Dutton & Ragins, 2009; Korte & Lin, 2013; Liu, 2013; Ljungholm, 2016; Nitzsche, Kuntz, & Miedaner, 2017; Read & Laschinger, 2015; Scrivens & Smith, 2013; Staber, 2006). The OECD (2001) defines social capital as 'networks together with shared norms, values and understandings that facilitate co-operation within or among groups' (p. 41). However, there is no single universally established definition.

The absence of an accepted definition of social capital demonstrates the complexity in defining the concept. Elements found in this study elucidate the interplay between individuals and the environments in which they work. IQRNs and AQRNs work together to develop professional relationships, cultivate trust and share a common purpose to deliver quality nursing care. The findings from this study propose that the nurses with whom one works and the environment in which one works determine whether the process of transition, adaption and integration into a complex healthcare setting is successful.

The relationship between people and their environment, described by the socioecological concept of social capital, 'provides a way of talking about and identifying the nature and impact of critical relationships between people from diverse backgrounds who need to cooperate and exchange information in complex systems' (Hofmeyer & Marck, 2008, p. 145). Developing professional relationships, having or giving collegiate support to develop trust and cooperative collaborations are ways in which the concept of social capital was conceptualised in this study. These findings are significant because of the link between social capital, personal capabilities and professional relationships. Fitting in to the cultural norms of a workplace, as

this study found, requires social skills, personal capabilities, personal readiness and motivation. IQRNs and AQRNs who have well-developed social skills and capabilities transition more readily into new practice contexts. This finding is noteworthy because well-developed personal capabilities have been associated with safe, quality nursing practice and quality patient outcomes (Amer, 2013). As others have argued, 'social capital as a process can contribute to our understanding of how social groups and social settings promote individual consequences' (Bankston III & Zhou, 2002, p. 312).

IQRNs and AQRNs adjust or amend behaviours, and this is seen as a process. RNs and IQRNs use social capital skills or personal attributes (resilience, interpersonal skills, teamwork, social intelligence, empathy, communication skills, emotional intelligence, confidence, reflexive practice) to fit in, cope, keep patients safe and deliver excellent nursing care. This study found that building up a workforce that invests in the social capital of the workplace is how leaders and organisations retain people to ensure a sustainable workforce. The culture of the workplace is dependent on excellent leadership within the work unit and the teams within. Similar studies with new graduates have found that 'authentic leadership and structural empowerment are key aspects of the work environment' and, as found in this study, these factors affect the development of strong teams and improve retention (Read & Laschinger, 2015). The findings from this study support Taorimina and Bauer's (2000) premise that the socialisation process of co-workers is influential in predicting satisfaction and commitment to stay, and this was similar across cultures. Professional socialisation develops professional identity and professional values, as discussed in the following sections.

6.4.3 Professional socialisation

Professional socialisation is the process by which nurses develop a sense of self as a member of the nursing profession, internalise the values of their profession and exhibit these values through their behaviour and actions. The findings from this study determined that having a strong sense of belonging and a strong professional identity play a role in professional socialisation. Professional socialisation is the internalisation of a set of values and the culture of the profession (Zarshenas et al., 2014). Values can be defined as the views that act as guides for individuals and organisations (Pendleton & King 2002; Stanley, 2016). Values are not

always explicitly stated; however, as this study found, *observing from the periphery*, nurses infer the values from the observable behaviours and actions of those around them.

IQRNs' experiences in understanding the culture of nursing in a new country are similar to those reported in studies with undergraduate nursing students and new graduate nurses (Davis, 2015; Stanley, 2016). Zarshenas et al. (2014) examine how nursing students' sense of belonging and professional identity contribute to professional socialisation. Results from their study show that nursing students' sense of belonging was related to theory–practice incongruence. However, this study concluded that IQRNs work hard to learn to fit in and to be accepted as a valued and trusted member of the nursing team, using both their experience and tacit knowledge, even though they also encountered incidences of theory–practice incongruence. In contrast to new graduates or nursing students, this study found that IQRNs and local RNs adjust to the cultural context of the work environment and understand how to *play the game*. Pearson (2011, p. 443) used the term clinical wisdom to describe how nurses 'size up' a situation:

> Much of our knowledge is tacit; we know we know but cannot always articulate what we know or how we came to know! Expert nurses possess deep sensitivity to the social, cultural and biological contexts of their patients and an ability to adapt rapidly to the unpredictable day-to-day dynamics of the hospital, clinic or community. When we are forced to explicitly describe our practice strategies we frequently reduce them to the more simplistic and mechanical concepts and strategies offered by official curricula and professional standards (even though we mostly know that such simplistic descriptions of what we are, are largely irrelevant to the complexity of our real work and accomplishments). The knowledge of expert practice cannot be grasped by someone who has not spent a significant amount of time immersed in day-to-day practices and our ways of knowing cannot simply be translated or reduced into the theoretical fields of biological and the behavioural sciences. Expert practice is, I suggest, characterized by a marrying of theoretical knowledge with practical wisdom. Practical wisdom in nursing relates to the ways in which we act, based on our interpretation of contextual particulars (Aristotle & McKeon, 1941). The aim of it is not to develop rules or techniques true for all circumstances, but to adjust knowledge to the peculiarity of local circumstance. Embodied in character and developed through

> habit, it is expressed through particular actions as to how individuals ‘size up’ a situation and develop and execute an appropriate plan of action.

While Pearson’s (2011) comments refer to contemporary nursing practice, comparisons can be made to ‘sizing up’ a situation when nurses from diverse backgrounds work together. IQRNs come from various foreign healthcare systems yet they also need to navigate processes on how best to position themselves in new practice contexts, while maintaining their own set of values. In addition, this study found that role modelling from existing staff and internal motivation were found to be factors that play a significant role in aligning professional identity. Authentic leadership was identified as crucial to support IQRNs during orientation, transition and adaption, as well as the local nurses they work with, as they learn to *play the game*.

The sociocultural perspective emphasises the situated nature of learning and socialisation. Sociocultural theory defines learning as a social practice (Vélez-Rendón, 2010). IQRNs and AQRNs engage collaboratively to construct and align knowledge and theory through engagement in clinical practice, attendance at orientation and education programs or in-services with experienced peers and mentors. Socialisation can be defined as the:

> process by which individuals acquire the knowledge, language, social skills, and value to conform to the norms and roles required for integration into a group or community. It is a combination of both self-imposed (because the individual wants to conform) and externally-imposed rules, and the expectations of the others. In an organizational setting, socialization refers to the process through which a new employee ‘learns the ropes’, by becoming sensitive to the formal and informal power structure and the explicit and implicit rules of behavior (Business Dictionary, 2019).

Key processes identified and used by nurses in this study to ‘fit in’ to a new workplace include problem-focused coping strategies and having social support at work. Coping mechanisms identified in *playing the game* included talking to a trusted colleague or peer, seeking social or emotional support, finding information and being reflexive. Less effective techniques included staying under the radar, avoidance, silencing, distancing or keeping to oneself, and taking time out in another area.

IQRNs from NESBs were fearful of speaking up when their English language was not proficient. The IQRNs feared being seen as incompetent if they could not find the right word or could not speak fluently to colleagues, doctors, patients and family members. This was interpreted by some as a lack of confidence and by others as incompetence. IQRNs had a genuine fear that they would lose their job if they spoke up about any problems or concerns. Yet the analysis of the findings from this study show that the reason for remaining silent is more ambiguous than speaking up. These findings support the research of Van Dyne, Ang and Botero (2003), who find that 'observers are more likely to misattribute employee motives for silence than for voice' (p. 1539). This is judicious because AQRNs and nurse unit managers (NUMs) who understand the significance of silencing demonstrated excellent leadership to repair damaging first impressions or false starts. Experienced nurses were able to rescue IQRNs who were not confident to speak up, ask for or accept assistance.

Several participants in this study—both AQRNs and IQRNs—left the area they worked in because of conflicts working with, or as, IQRNs. Several studies have found that distancing oneself from situations that are perceived to be difficult can allow time out and provide space to reflect on the incident or situation, reduce stress and avoid burnout or compassion fatigue (Lim, Bogossian, & Ahern, 2010; Severinsson, 2003). This finding is significant because it is commonly known that compassion fatigue affects staff wellbeing, decreases resilience and ultimately affects the retention of experienced staff. In this study, the continual cycle of staff turnover in the Australian healthcare system, including international nurses, affects local nurses' reserves when they are not supported by management with the necessary additional resources, which leads to compassion fatigue for fellow colleagues.

A significant finding of this study was the influence of professional development opportunities and support of the local workforce on IQRNs learning how to fit in and play the game in the Australian context, regardless of cultural background. The effect of professional development and professional identity is discussed in the next section.

6.4.4 Professional identity

Professional development can be shaped by professional identity factors including language, ethnicity and cultural background, country of origin, education, gender and age (Smith, 2010; Toarniczky, 2011). This study found that IQRNs' professional identity is influenced by

contextual factors inherent in the work environment, including policy, cultural differences, values and beliefs, organisational norms of practice, geographic location and access to appropriate information and resources. While diversity within Australia's multicultural nursing workforce is the norm, the literature on international nurses often refers to race, country of origin, ethnicity or English as a second or third language.

Interestingly, the results from this study found that it is not where nurses come from, the language they speak or the education they received that is germane; rather, it is learning how nursing is conducted in this country. Learning the expectations of the RN role, scope of practice and culture of the work environment are important considerations. It is not the education background of the nurse that is the issue, but how their beliefs, values and norms of nursing practice from previous experience align with the Australian context and the capacity of nurses to work together and support each other to deliver best practice for safe, PCC. Fagermoen's (1997) study on professional identity and values states that 'values are inherent in developing and sustaining professional identity and are expressed in … actions in relation to others' (p. 436). As the findings of this study indicate, the process of professional socialisation fosters and cultivates professional identity. This study found that leadership is a key influence and is critical to developing professional identity, skills and knowledge in local contexts to enhance the practice and experience of the international and local nursing workforce in delivering healthcare (Kunaviktikul, Turale, & Stone, 2018).

6.4.5 Leadership

In this study, when there was good leadership and adequate resources, the transition and integration experience of IQRNs was satisfactory. Good leadership was visible at the coalface by NUMs who were actively involved in the recruitment process and with actions to support both AQRNs and IQRNs new to the position. However, when the leadership was not as strong or as visible, the experience for IQRNs and AQRNs was less satisfactory. Nursing team confidence and faith in the leadership and the organisation's processes were compromised, environments became negative and experienced staff did not stay. Participants were critical of management, and ineffective leadership influenced workplace morale. Dysfunctional direction is a causal explanation when RNs are part of the problem. Authentic leadership theory 'can be used to educate future leaders and has the potential to improve leadership

development strategies and positive outcomes in healthcare workplaces' (Alilyyani, Wong, & Cummings, 2018, p. 33).

Studies indicate that strong leadership is necessary in functional and efficient workplaces (Harvey et al., 2018; Stanley, 2016). This study found that leadership also influenced the culture of the environment and whether people want to stay or leave. A closed unit occurs when a local workforce is resistant to newcomers, making it difficult for any IQRN to fit in to the cultural norms, irrespective of where they came from. However, when congruence between the leader's values and beliefs matches their actions, nurses felt supported by these champions in the unit. These authentic leaders influenced team processes and outcomes through role-modelling behaviours. Leaders who demonstrate self-awareness and authentic leadership, including structural empowerment and team reflexivity, guide and develop others via mentorship, role modelling and promotion of leadership education (Lyubovnikova, Legood, Turner, & Mamakouka, 2017). This study found that transformational leadership that encourages the empowerment of nurses increases job satisfaction among nursing staff. Empowerment as the mediator is an effective strategy that has a positive effect on job satisfaction and intention to stay (Choi, Goh, Adam, & Tan, 2016).

The meaning of reflexivity, which is often noted as an individualistic Western construct as opposed to a collectivist context (Alvesson & Skoldberg, 2009; Emirbayer & Desmond, 2012), must be expanded to reflect how IQRNs and AQRNs might engage in the process of reflexivity. This study found that nurses use reflexivity as a process to evaluate their position and actions and behaviours to improve their understanding of how to play the game and fit in to the cultural norms of the workplace. Conversations with trusted colleagues in formal and informal settings assisted in this process. Alilyyani et al. (2018, p. 62) recognise that:

> healthcare organizations need leadership from individuals who exhibit sound relational skills and authentic concern for their staff as persons and who can communicate honestly and openly with others to achieve positive outcomes for their staff, patients and organizations.

Building capacity for nurse leadership can be achieved via role models, peer support and mentoring partnerships. What is known is that relational leadership and authentic concern for

staff are positively linked to improved outcomes in healthcare organisations for staff, patients and the organisation via leadership development strategies (Alilyyani et al., 2018; Cummings et al., 2010).

6.4.6 Professionalism

Professionalism is an expected and mandated core skill in nursing in Australia. IQRNs face additional challenges traversing the political and cultural landscape within healthcare facilities to deliver competent nursing care. This study found that challenging the status quo was a difficult process for IQRNs. Navigating nursing practice in new contexts required IQRNs to reflect on their previous practice while navigating local expectations. Other healthcare professions, including the medical profession, also have high rates of internationally qualified practitioners in the Australian healthcare system; however, their experience is different to that of IQRNs. Holt (2000, p. 1) argues:

> Medical consultants make time to influence the environment in which they work, nurses do not. Part of this is about socialisation, and overcoming traditional cultural roles, and part of this is about overcoming fear of being different, wrong or even ignored.

An exemplar from an emergency nurse's experience in a department outlines how playing the political game can advance nursing. While not specifically discussing the role of diversity within the healthcare workforce, parallels are drawn to Holt's (2000, p. 1) observation of how political gains underpin workplace politics:

> In many ways culture is an area we have the least and the most influence over. The way we behave ourselves should be controllable, but the attitudes and behaviours of others is more difficult to influence. The former, however, affects the latter. It often strikes me how much more polished some of our medical colleagues are in presenting an argument, in outlining what they are prepared to accept, and in getting their own way. This is not simply because they are perceived as more powerful, or more important; it is about professional confidence, single mindedness and coherence. As a profession, nursing still lacks much of this polish as we are not socialised to promote

> our own worth and our own needs in the same way, but to impact on the public and political agenda to the same degree, we need to adopt some of the same behaviours.
>
> We need to value our own skills and experience, individually and as a profession, but also we need to look at why … we still expend such a large amount of energy on criticising, complaining, and worst of all disagreeing about our work. Most of us know implicitly what is good for patients.

Playing the game and navigating workplace politics proved to be one of the challenges faced by IQRNs. Maintaining a professional attitude and acting in a professional manner were deemed to be essential factors in learning the rules and playing the game.

6.4.7 Diversity

This study maintains that when working with diverse groups of nurses in practice, the additional time and resources that are needed to invest in and address issues is not taken into consideration by organisations. The findings from this study reveal that the level and type of diversity in the workplace can influence the experience of both IQRNs and AQRNs. Diversity can be described as social variation in relation to age, gender, ethnicity and country of origin (Smith, Allan, Henry, Larsen, & Mackintosh, 2006). Diversity in knowledge, skills and educational preparedness can be described as functional or informational diversity. Interestingly, while these terms are used by van Knippenberg, De Dreu and Homan (2004), the results of their study propose that 'attempts to link the positive and negative effects of diversity to specific types of diversity should be abandoned in favor of the assumption that all dimensions of diversity may have positive as well as negative effects' (p. 1008). This goes part of the way to explaining this study's findings that describe why cultural diversity in the nursing profession adds to the complex nature of socialisation and how time is a factor that is often overlooked as a legitimate cost to overcoming some of the specific barriers to transition. The cultural dividend provided by IQRNs is widely acknowledged in this study. Despite their differences, nurses must work together to deliver quality nursing care to diverse populations in the settings in which they are employed (ANMAC, 2012).

The nursing profession is consistently ranked as the most honest profession by the public worldwide (Brenan, 2017; Carroll, 2004; Jones, 2016; Santamour, 2012). This accolade is both

well-deserved and a paradox. While nursing is held in the highest regard by the public, the literature is replete with exemplars of nurses 'eating their young' (Almost et al., 2016; Castronovo, Pullizzi, & Evans, 2016; Hamblin et al., 2015), bullying behaviour (Hartin, Birks, & Lindsay, 2018; Livne & Goussinsky, 2017; Ross, 2017) and racism (Ludwig-Beymer, 2017; Thorne, 2017) occurring within its ranks. This is common to all countries and across all borders. As a highly educated and skilled profession, these issues persist and are sustained in the nursing culture despite evidence that highlights the detrimental and negative effect of such behaviour (Skinner, Van Dijk, Stothard, & Fein, 2018). However, as reported in this study, IQRNs must navigate between what the profession expects and what the public demands. Navigating this minefield is fraught with contradictions. Therefore, right in the centre of a contradiction is where the energy is. This study found that while nurses are committed to working together towards common goals, incidences of bullying and racist behaviour were also reported.

The findings from this study have been supported by the extant literature to explicate the GT *playing the game*. Collectively, organisational socialisation, professional socialisation and individual processes combine to provide a meaningful representation of integration processes presented in the phase *learning the game* and embedded in the GT *playing the game*.

6.5 Playing by the rules

Concepts that influenced participants' ability to *play by the rules* include *collaboration*, the existence of *champions* and a culture of *person-centred care*. These factors are discussed in this section, along with their relevance in establishing *positive workplaces*.

6.5.1 Collaboration

Collaboration is more than just working together. The findings of this study confirmed that collaboration entails mutual and authentic connections between IQRNs and local RNs, including clinical educators, clinical nurse preceptors, mentors and nurse managers. The effect or nature of the socialisation process on nurses is related to the collaborative experiences of those that work together in a particular work context or environment (Read & Laschinger, 2015; Zarshenas et al., 2014). Yet as in many professional environments, this study confirms that to succeed in nursing, one must know how to *play the game* and *play by the rules*—that

is, learn to navigate workplace politics and have an understanding of the workplace dynamics in the organisation or facility.

This study established that tacit workplace norms and politics exist in every workplace, so it is important for nurses to be able to navigate the system. Understanding the politics of the organisation or work environment requires a high level of emotional intelligence and an understanding of others' behaviours and actions in the practice setting (Almost et al., 2016; Jada, Jena, & Pattnaik, 2016). The theory of *playing the game* abstracts the political undertones present in workplace environments and extrapolates the processes that underpin actions from the perspective of both newcomers and long-term employees.

People generally justify their own behaviour; however, political undercurrents that prevent nurses from focusing on their work, reduce individual potential, impede collaboration and create mistrust among staff have far-reaching consequences (Choi et al., 2011). The results of this study found that this is particularly salient for nurses who received their nursing education in a different country to that in which they are practicing. This study found that IQRNs need to find ways to understand how they can contribute and fit in to their new context, as do the nurses they are working with. It is essential that local nurses remain open to different worldviews of nursing and embrace the unique experiences and skills that international nurses contribute to nursing knowledge and clinical practice. Pung and Goh's (2017, p. 146) integrative review on challenges faced by international nurses concludes:

> With good integration international nurses may be able to reach their full career potential as professional nurses in their host countries. The adaptation process is a dynamic process that requires effort from both international and native nurses. Thus, any strategies that are developed and implemented must be multifaceted.

The results from this study revealed that forming alliances with others is one process that nurses use to stay centred and in control of their practice while maintaining their integrity, culture and beliefs. IQRNs from healthcare settings that have varied philosophies of what and how nursing care is delivered may have different perceptions of how nurses work collaboratively towards the same shared goal of quality PCC (Campinha-Bacote, 2010). Thus, nurses need to gain the confidence and respect of their colleagues and develop trusting and

meaningful working relationships. Nurses who engage with others and form bonds increase their standing within the team (Watson, 2008).

This study also highlighted that nurse managers need to ensure that all nurses are treated equitably in all workplaces; however, this is not always the case. Application and promotion processes need to be transparent and ethical—for example, a promotion should be earned or based on merit, not obtained because the nurse is an AQRN. As other studies have found, moving up within an organisation presents unique challenges (Thomas & Osborne-McKenzie, 2018). There were several reports of IQRNs not receiving promotions over AQRNs despite having the same level of qualifications and years of experience. Skinner et al. (2018, p. 200) find that the experience of injustice has implications for nurse managers and identifies:

> the need for managers to engage in regular conversations regarding systemic barriers to performance and implementing performance management as an ongoing dialogue designed for employee voice and relationship management. This process also suggests a need for leadership development in nursing management. Using such steps and strategies would significantly enhance best practice in nursing management.

In contrast, several IQRNs detailed how they obtained a promotion in an Anglo-centric workplace and gained the respect of colleagues by using social skills and being savvy to the political nature of nursing.

6.5.2 Champions

Codes identified early in the study were subsumed into the category of championing. These were nurses called champions, who welcome newcomers, supporting both new and local staff to work to their full potential in collegiate and professional teams. This finding recognises champions to be important positive influencers. Findings from this study support those of Miech et al. (2018), who find that champions, also referred to as facilitator, key influencer, cheerleader and main supporter, are crucial in healthcare and are a positive influence on implementation effectiveness.

In this study, champions were in vivo codes (‘*stopping wildfire into the unit*’ and ‘*having a canary in the unit*’) that described the efforts and behaviour of staff who responded to incidents related to IQRN and AQRN transition. Having a canary in the unit was a term to

highlight how one person can identify or be the one who undermines a team. Champions understood this and acknowledged information from others, but they were also steadfast to ensure innuendo did not promulgate bias, prejudice or misinformation. Having the measured support of a champion enabled individuals and teams to interact in positive and safe environments (Miech et al., 2018; Ramji & Etowa, 2018). As the findings from this study illustrate, this becomes critical when there are discrepancies between personal, professional and organisational expectations of nursing practice. This study found that conflict between actual expectations of practice in the local context contrasted with IQRNs or AQRNs' own practice standards of PCC. Sharp, McAllister and Broadbent (2017) conclude that 'organisations and individuals striving for person-centred care need to develop awareness of the social and political forces that shape and constrain practice, in order to approach their work more consciously and critically' (p. 1).

6.5.3 Person-centred care

Nursing in Australia has a person-centred philosophy, and the model of PCC is practiced in most settings (Queensland Health, 2016; Waters & Buchanan, 2017). This study found that some IQRNs were not familiar with the model of PCC. In supportive workplaces, opportunities to learn and understand the premise of PCC are created (Waters & Buchanan, 2017). However, this study set out to examine the process used by nurses to work together when they come from diverse nursing educational preparedness, cultures and backgrounds. Thus, a significant premise of this study was examining the relationship between IQRNs and AQRNs. The construct of relationship-centred care described by Croker (2011, p. 18) demonstrates how patient-centredness has informed a similar perspective of healthcare, as found in the results of this study:

> Patient-centredness has also informed other views of health care. Relationship-centred care, for example, is grounded in the notion patient-centredness but is explicitly concerned with the relationships between people in health care. Beach, Inui, and The Relationship Centered Care Research Network (2006, p. 4) explain that relationship-centred care —embraces and expands the principles of patient centeredness within the patient-clinician relationship and considers—the

relationships of clinician-clinician, clinician-community, and clinician-self as foundational and intrinsic to health care.

The significance of the RN-to-RN professional relationship found in this study reiterates the importance of strong professional working ties. Strategies are needed to support both the IQRNs and the local workforce to better understand what is necessary to safely transition new staff from foreign health services into the Australia healthcare context (Ohr, Brazil, & Holm, 2016; Ohr et al., 2014). This study suggests that it is not about race, culture or country of origin, per se, but about aligning professional values and having a mutual understanding of what the model of nursing practice within the Australian context entails.

6.5.4 Positive workplaces

Nurses often work in dynamic healthcare environments, both positive and negative. The term, *the maelstrom*, derived from this study, is an in vivo code used to describe the dynamic work milieu in which nurses work on a daily basis. Factors include 24/7 staff rostering, skill mix within teams, patient acuity and dynamics of working in multidisciplinary healthcare teams, often inclusive of IQRNs, IMGs and other HCPs. In this study, *the maelstrom* reflects the constant state of flux encountered in dynamic workplaces. Nurses and other members of the healthcare team face constant demands in their work environment to meet a variety of competing demands. Hofmeyer and Marck (2008, p. 145) affirm that nurses and managers work 'within the complex moral terrain of strained relationships and turbulent healthcare systems'. Organisations need to acknowledge the critical link between the number and skill mix of nurses, 'the characteristics of the work environment and the impact on patients, nurses, and the system as a whole' (Stone et al., 2003, p. 120). The role played by positive work environments in enabling nurses to succeed and work effectively together is well documented (Bowen, Privitera, & Bowie, 2011; Dawson, Stasa, Roche, Homer, & Duffield, 2014; WHO, 2016a). In contrast, the effect of negative workplaces on staff morale and retention is also documented (Terzioglu, Temel, & Uslu Sahan, 2016).

The advantage of creating a positive work environment is the ability to deliver a consistent approach to healthcare delivery that aims to maintain and improve quality patient care delivery and to sustain clinical efficiency. This study found that organisations that value and support nurses through education, supervision, mentoring and preceptorship found nurses to

have a positive attitude towards the facility and their colleagues and were more likely to plan to stay. This occurred across all sectors, including aged care. Chenoweth, Merlyn, Jeon, Tait and Duffield's (2014) study on nurses working with persons with dementia in acute care, residential aged care and community settings found that one of the intrinsic factors to retention included positive work relationships with colleagues. Similarly, extrinsic factors include support from the organisation. Professional development opportunities had a positive effect on retention. As this study found, nurses feel valued when they are supported by organisations and colleagues through ongoing education, in-service training and mentoring or preceptorship opportunities. *Playing the game* incorporates building positive relationships with other staff. Of interest, 'playing the game' is a term used by Lim et al. (2010) as a coping mechanism. Some studies refer to building positive relationships between family, carers and healthcare professionals across facilities over time as 'playing the game'. Strategies include the use of humour and whatever it takes to foster positive relationships (Quinney, Dwyer, & Chapman, 2017).

While the advantages of a positive work environment are documented in the findings in this study, the findings also revealed that a *closed* unit is one that is resistant to newcomers. The findings suggest that existing staff do not want the additional work of training a newcomer or upskilling an IQRN. This was seen to be a result of continual turnover, ESL constraints, upskilling requirements, care standards not being met, or being discriminatory or racist based on the IQRNs' background, educational preparedness or culture. The study found that it is often older, experienced RNs who have suffered burnout, are less tolerant of newcomers, less trusting and just want to get through a shift and not be responsible for another new staff member. Evidence of similar experiences among RNs and other HCPs not wanting to work with undergraduate nursing students or new graduate nurses is documented in the extant literature (Carvalho, Guerrero, & Chambel, 2018; Hegney et al., 2014).

As this study has affirmed, there are positive and negative environments. Positive environments depend on the team, leadership and group interactions (Halter et al., 2017). This study's findings revealed that positive work environments demonstrate good leadership, positive interactions among team members and affirmative welcoming interactions with new staff. This then creates an environment that enables people to fit in. The features that make a unit open included people being open to having new staff and leaders who support new

people coming in (Madden, Mathias, & Madden, 2015). Factors that were seen to not enable people to fit in included older RNs who did not like change, new people or changes to routines. There were also incidents reported of racist and discriminatory behaviour against IQRNs from specific countries, including Africa, India and Nepal.

Group cohesion is demonstrated in teams in which each nurse feels a sense of belonging. This in turn reflects or influences their level of job satisfaction (Thomas, 2004). It is well documented that good relationships with other nurses is critical to job satisfaction, reduces potential for burnout and increases the sense of personal accomplishment (Thomas, 2004). Other studies have revealed a link between job satisfaction and nurses' role competence, contact and proximity to capable nurses and access to in-service or educational programs (Jakimowicz, Perry, & Lewis, 2018; Sawatzky, Enns, & Legare, 2015). An Australian study of the general nursing workforce by Hegney et al. (2014) linked compassion fatigue to potential burnout in nurses, which in turn affected retention. Negative work environments were found to affect nurses physically, emotionally and mentally, which placed their health and wellbeing at risk and undermined their ability to provide quality nursing care. The theory of *playing the game* involves navigating political undercurrents that are inherent in most work environments and finding meaningful engagement with others. These processes are complicated to learn and understand when the work environment, captured in the phrase *playing the field*, is in a constant state of flux, as reflected in the metaphor derived from this study as *the maelstrom*.

6.6 The end game

In the end, how the game is played determines whether it is *win*, *lose* or *draw*. Key factors that affect this outcome and warrant discussion are *cultural competence* and *incivility*.

6.6.1 Win, lose or draw?

This study provided evidence that effective leadership and preceptorship increases group cohesion and nurse retention. This finding supports the results from Halter et al.'s (2017) systematic review, which concludes that leadership and preceptorship are valuable strategies for human resource managers to consider in relation to retaining experienced nursing staff. Given that the cost of recruitment and staff turnover is significant to an organisation, investing in recruitment strategies is prudent (Halter et al., 2017; ICNM, 2018; ICN, 2018; Russell et al.,

2017). The results of a comparative review of nursing turnover costs in four countries (US, Canada, Australia and New Zealand) conducted by Duffield et al. (2014, p. 2703) found that a significant proportion of turnover costs is attributed to temporary replacement, highlighting the significance of nurse retention:

> Australia reported significantly higher turnover costs ($48,790) due to higher termination (~50% of indirect costs) and temporary replacement costs (~90% of direct costs). Costs were almost 50% lower in the US ($20,561), Canada ($26,652) and New Zealand ($23,711). Turnover rates also varied significantly across countries with the highest rate reported in New Zealand (44.3%) followed by the US (26.8%), Canada (19.9%) and Australia (15.1%).

Lower turnover in Australia may be explained because the Australian data from Duffield et al.'s (2014) study were collected during the GFC, which may reflect the fact that fewer staff left the profession during that period of uncertainty and instability.

The results of a study on the critical care nursing workforce by Jakimowicz et al. (2018) examines 'factors predicting and contributing to compassion satisfaction and compassion fatigue experienced by critical care nurses [CCNs] in Australian intensive care units' (p. 403) and concludes that there is a need for further research into retaining critical care nurses:

> This first phase of a larger research project supports the need to conduct qualitative research to further explore the sources of CCNs' satisfaction or dissatisfaction in their challenging role … Future research is needed to better understand what enhances compassion satisfaction in this high-stress environment and what interventions could be employed to retain and maintain this crucial critical care nursing workforce.

The findings from this study extend those of Jakimowicz et al. (2018) in supporting retention strategies for the existing local workforce. While the findings were specific to the critical care context, there are similarities found across the sectors. An important finding from this study suggests that job satisfaction is linked to workforce retention and quality of care. Previous studies have also concluded that these are the key predictors to retaining experienced staff (Sawatzky et al., 2015; Simpson & Knott, 2017; Van Osch, Scarborough, Crowe, Wolff, & Reimer-Kirkham, 2018). Further, a study by Brook et al. (2018) suggests that orientation and

transition programs that occur over an extended period and include a preceptor and mentor component are an effective retention strategy.

6.6.2 Cultural competence and incivility

There is a need for cultural competence and safety, as well as orientation and jurisprudence for international nurses regardless of where they come from. Cultural competence encompasses the attitudes, knowledge, skills, behaviours, desires and encounters required to appreciate and understand cultural differences between groups of people (Lin, Lee, & Huang, 2017). A person's cultural identity is formed by their language, race, ethnicity, values and beliefs, and country of origin (Raigal-Aran, Ferré-Grau, & Belzunegui-Eraso, 2018). RNs receive education and attend programs on cultural safety for patients, clients and consumers of healthcare (Norton & Marks-Maran, 2014; Williamson & Harrison, 2010), but there is less emphasis on the awareness of cultural safety between nurses.

Australia's multicultural population necessitates that all RNs must have cultural awareness to provide culturally congruent and culturally competent care. The provision of safe, culturally appropriate care to patients from diverse backgrounds, ethnicities, religions, values and beliefs that are different to their own is vital. While many organisations provide compulsory cultural safety programs, these are often a half- or single-day session that addresses the needs of the population. However, despite nursing education and orientation programs providing information on cultural issues, they are not designed to address cultural humility within the workforce, inclusive of IQRNs who form approximately 30% of the RN workforce in Australia.

Similar to the experience of IQRNs in this study, international students studying nursing, medicine or speech-language pathology also navigate how to function in unfamiliar healthcare systems (McKenna, Robinson, Penman, & Hills, 2017). Correspondingly, learning the nuances of Australian English and communicating in culturally appropriate ways compound the transition into clinical practice. The IQRNs in this study were also exposed to discrimination and bullying. This is a disturbing finding echoed in an Australian study on bullying and the nursing profession (Hartin et al., 2018) and in previous international studies (Likupe, 2006; Nichols & Campbell, 2010; Pung & Goh, 2017; Walker, 2010; Wheeler, Foster, & Hepburn, 2014; Xu, 2007, 2008).

It is imperative and incumbent on the nursing profession to ensure that IQRNs are given the best opportunity to integrate successfully into a foreign healthcare system. This research demonstrates that 'winning the game' requires specific and individualised orientation and support to transition IQRNs safely into the work milieu while supporting existing local staff. As with new graduate nurses and any new employees, the goal is to provide a workplace in which these nurses can thrive and succeed in their professional role—an outcome that is measured by increased retention and positive work satisfaction scores. This study contends that strategic and critically important strategies to support both IQRNs and the local RNs requires adequate resources. Appropriate support will enable IQRNs to integrate successfully into the healthcare service and local workforce. The findings of this study bring us closer to understanding the collective experiences of AQRNs and IQRNs working in Australia and, more generally, of the process used by IQRNs transitioning from one culture to another in a new healthcare environment amid unfamiliar customs, cultural traditions, professional norms and social expectations. When AQRNs and IQRNs are prepared and supported to adapt to working together, everyone wins.

6.7 Chapter conclusion

This chapter discussed the study's findings in the context of existing theories and extant literature. Professional and organisational socialisation theories reflect the junctures of adaption and integration that internationally qualified nurses undergo as they learn how to *play the game*. Adapting to the cultural context of the workplace is a dual interaction mediated by regulatory, political, managerial and interpersonal constructs within dynamic work environments. This chapter highlighted the theoretical contribution that the GT *playing the game* makes to nursing knowledge. The aim is to translate these findings to inform actions and policy, as discussed in the next chapter. The final chapter evaluates the theory of *playing the game* for credibility, originality, resonance and usefulness. Recommendations for future research in education, policy, practice and research are made, and the strengths and limitations of the study are identified.

Chapter 7: Conclusion

Vistas for the future

From explanation to determination

7.1 Introduction

This chapter recounts the aim and the resultant findings of the study that answered the research question posed in Chapter 1. The background, research design, methodology and methods used in the conduct of this study and the ensuing findings were explicated in the preceding chapters. The GT developed from this research has been presented and discussed in the context of the extant literature and the contribution it makes to nursing discourse. This chapter completes the thesis with an evaluation of the GT. The quality and rigour of the research process and product are confirmed. Implications and recommendations derived from the research findings are presented, along with suggestions for areas of future research. This chapter concludes with a review of the study's strengths and limitations.

7.1.1 Recounting the study aim

The aim of this study was to explore how IQRNs and AQRNs adapt to work together in the Australian healthcare system and to develop a theory that explains this process. A GTM was selected to underpin this study and answer the research question posed: What is the process by which IQRNs are integrated into the Australian healthcare system? The impetus for the study was to understand the process of transition, adaption and integration of IQRNs into the Australian healthcare system. The study examined the phenomenon from a dual perspective because few previous studies have examined the process behind the integration of international nurses with reference to perspectives from the host country. The findings from this study have been integrated into the GT *playing the game*.

7.2 Evaluation of this theory

The quality of this study is demonstrated in the meticulous conduct and application of the GT methods in the collection, generation and analysis of the data throughout the study. Birks and Mills (2011) state that it is the 'processes that determine the relevance and value of data'

(p. 146), yet evaluating the GT research requires a comprehensive appraisal 'beyond the processes by which it was derived' (Birks & Mills, 2011, p. 152). An evaluation of this research is considered in two areas: evaluation of the research process and evaluation of the product of the research. Each of these will be discussed in the following sections.

7.2.1 Evaluating the research process

In GT, factors that influence the quality of the research include the expertise of the researcher conducting the study, congruence of the methodology with the research question and procedural precision in employing the essential GT methods (Birks & Mills, 2015). Evidence that the theory has been evaluated using the criteria for GT research is summarised in Table 7.1.

Table 7.1. Criteria for Evaluating GT Research (Adapted from Birks & Mills, 2015, p. 147)

Domain	Criteria met	Evidence
Researcher expertise	Demonstrates skills in interviewing and scholarly writing Evidence researcher is familiar with GT methods Citations of relevant methodological resources presented Limitations in study design and research process acknowledged	Chapters 1–6 Publications that arose from this research are presented in Chapters, 2, 3 & 5 Chapters 1–7 Chapter 7
Methodological congruence	Researcher has articulated philosophical position GT has been determined to be an appropriate research strategy for the stated aim of the study Outcomes of research met the stated aim GT is presented as the end product of the research	Chapters 1, 3 and 7 Chapters 1, 3, 4, 5 and 7 GT methods employed meticulously to generate final GT *Playing the game*
Procedural precision	Evidence memoing was conducted throughout study Audit trail maintained Procedure for management of data and resources described Evidence the researcher has applied the essential GT methods applied appropriately in the context of the study The final GT is credible	Chapters 3, 4, 5, 6 and 7 Study design developed Memoing Use of NVivo Evidenced the theory is grounded in the data Final GT evaluated and published in peer review journal

As shown in Table 7.1, the researcher has demonstrated a significant level of expertise, methodological congruence and procedural precision relative to the conduct of this study. Further, the researcher has demonstrated expertise as an invited speaker by disseminating this research through various means, including local, national and international nursing and research conferences (see Appendix H). Further, three peer-reviewed publications were published from this research; first, the research design developed for this study (Chun Tie, Birks, & Francis, 2019); second, the integrative literature review (Chun Tie, Birks, & Mills, 2018); and third, the GT *playing the game* was in press at the time of thesis submission (Chun Tie, Birks, & Francis, in press).

Methodological congruence was demonstrated as the methodology, and the philosophical position of the researcher and the research design were appropriate and aligned to answer the research question and achieve the aims of this study. Procedural precision in the meticulous application of the essential GT methods is evident in the quality of the final product, as discussed in the following evaluation of the GT *playing the game*.

7.2.2 Evaluating the research product

Evaluating the product of GT is an evaluation of the final theory itself. The application of evaluation criteria is a useful guide to appraise the results of the GT (Chiovitti & Piran, 2003). The goal in generating an abstract theory is to offer the reader 'a conceptual explanation of a latent pattern of behaviour that holds significance within the social setting under study' (Holton, 2007, p. 268). The product of the research can be evaluated using criteria that seek to determine and verify the credibility, originality, resonance and usefulness of the research findings (Charmaz, 2014) (see Table 7.2).

Table 7.2. Evaluating the Product of the GT Playing the Game (Adapted from Charmaz, 2014, p. 337)

Evaluation criteria	Questions
Credibility Originality Resonance Usefulness	Does this theory appear as a credible representation and resonate with your own experiences? Does it make sense and have a logical flow? Does the research establish relevance and usefulness in practice? Have you learned something new? Are there any gaps?

The evaluation criteria presented in Table 7.2 assist in the critique of how the theory was constructed through reference to the implicit actions and meanings in the studied phenomenon. Charmaz (2014) suggest evaluation 'criteria account for the empirical study and development of the theory' (p. 338).

7.2.2.1 Credibility

In this study, the researcher used several methods to enhance credibility in research practice and ensure rigour. According to Beck (1993), credibility relates to 'how vivid and faithful the description of the phenomenon is' (p. 264). That is, it relates to the trustworthiness of the findings presented. In qualitative research, credibility is demonstrated when 'informants, and also readers who have had the human experience recognize the researcher's described experiences as their own' (Beck, 1993, p. 264). The GT *playing the game* was presented to two separate focus groups of AQRNs and IQRNs who work in a range of healthcare sectors and in varying nursing positions across Australia.

The focus groups were conducted with the aim of evaluating and validating the GT *playing the game*. The GT was presented in a PowerPoint presentation inclusive of the diagrams as presented in Chapter 5. The use of diagrams to support and disseminate a visual representation of the data, and the resultant GT, inclusive of metaphor and illustration, is an effective means for disseminating information to critical audiences. Buckley and Waring (2013, p. 169) state 'visual representation can facilitate deeper understanding by providing an alternative form of communication that is accessible to a wider audience than text alone'. Each of the four categories—*joining the game*, *learning the game*, *playing by the rules* and *the end game*—were presented to the focus groups. The participants were asked questions by the researcher if the analysis made sense to them and if their experience matched the theoretical GT *playing the game* as presented in Figure 7.1. The questions put forward to each focus group member to evaluate the GT are listed in Table 7.2. The validation process using focus groups is also termed 'group validation interviews' and is where 'the participants are working deductively' as the researcher seeks agreement or disagreement with the theoretical rendering of the GT (Morse, 2007, p. 241).

Figure 7.1. Evaluation criteria for GT using focus groups

Presenting the GT to two separate focus groups of new, experienced and senior AQRNs and IQRNs from different healthcare sectors working across Australia gave the participants an opportunity to provide feedback and confirm an independent assessment of the GT *playing the game.* As a result, the participants in each group subsequently concurred and supported the findings presented as credible.

7.2.2.2 Originality

The GT *playing the game* presents an innovative conceptual rendering of the data and tenders a contemporary theory that answers the research question. Evaluating the originality of the GT *playing the game*, the researcher reviewed the analysis and categories with the researcher's advisory panel. Undertaking extensive analysis provided a renewed conceptual representation of the data, demonstrated through the application of metaphors to highlight complex processes and extend current concepts in contemporary practice. The theoretical significance of this study was explicated in detail in Chapter 6. The acceptance of peer-reviewed abstracts at local, national and international nursing and research conferences supported curiosity in the topics presented. Presenting the GT *playing the game* as a visual representation and acceptance for publication in Australia's leading peer-reviewed nursing journal (*Collegian*) is testament to the originality of this theory within the nursing profession.

7.2.2.3 Resonance

Evaluating the GT using the criteria of resonance was undertaken throughout the research process. This study revealed the 'taken-for-granted meanings', but also revealed the liminal meaning from participants. In doing so, links between organisational processes and individual participants were clearly articulated. The GT made sense to the researcher, the advisory team and each participant in the two focus groups. Participants in both focus groups confirmed that the analysis that was presented offered deep insights into the process of transition, adaption and integration from the perspective of IQRNs and AQRNs who have experienced this phenomenon. The participants agreed that it resonated soundly with their own experiences of working in the Australian healthcare system. Participants' quotations used in this thesis and in the manuscripts published from this study demonstrate that the GT reflected their individual and collective experiences.

7.2.2.4 Usefulness

Reflecting on the process of conducting a GT study required the researcher to be fully immersed in the process. Analytical leaps of faith were taken along the way to reach the endpoint of a substantial systematic and reasoned rendering of the data, presented in a visual representation of the GT *playing the game*. The evaluation of this GT demonstrated a robust and compelling combination of credibility and resonance that enhanced the usefulness and potential value of the theory to practice by positioning the theory in the extant socialisation, organisational and psychology literature. The practical application of the results of a GT is a measure of its value (Birks & Mills, 2015). The participants in each focus group agreed that the GT offered an analysis of the data interpreted in a manner that nurses can readily understand and take back to their respective work areas to use in their everyday practice. The GT *playing the game* contributes knowledge to the nursing literature to improve the process of transition, adaption and integration of IQRNs and AQRNs working in the Australian healthcare system.

Evaluating this GT required 'reasoned reflections and principled convictions' (Charmaz, 2014, p. 338) to ensure a meaningful and valuable contribution to the nursing and healthcare literature. This new knowledge has the potential to improve the transition and adaption experiences of IQRNs and AQRNs and, as such, enhance their retention in the workforce. The

final theory also has a potential reach beyond the nursing profession to other healthcare professions that employ internationally qualified healthcare professionals.

7.3 Implications of this theory

Assessments of IQRNs for skilled migration and registration are separate processes that IQRNs must navigate to be eligible for registration to practice as an RN in Australia (COAG Health Council, 2017). These processes include recruitment organisations, the immigration department, NMBA, AHPRA and employing organisations. In addition to gaining registration from the NMBA, some IQRNs may need a skilled migration visa, which is issued by the Department of Home Affairs.

A review by the COAG Health Council (2017, p. 148) states:

> It may also offer opportunities for higher education providers to develop educational programs to facilitate the transition of internationally qualified practitioners into the workforce … The ability to practise under supervision can be useful for overseas trained practitioners as they transition to working in the Australian health system. However, … when setting requirements for supervised practice, National Boards should provide clear guidance on the competencies to be acquired and differentiate these from progressive work experience and ongoing professional development expectations

The work in this study aims to go beyond what is already reported in the literature. The findings recommend the development of an online orientation program for IQRNs entering Australia. This program should be designed to prepare IQRNs to address the cultural shock they face when moving into a healthcare system that is foreign to the one from which they have come. The aim is to provide support for IQRNs migrating to Australia. The responsibility lies with regulators, organisations and AQRNs and IQRNs to enable CaLD workforces to work safely and effectively together to provide safe, culturally congruent care.

Internationally, planning needs to occur to maintain and sustain a reliable and safe workforce for the future. Recruitment of international nurses remains a short-term strategy; however, it does not address issues relating to retention. Recruitment of IQRNs can create problems when

conflict occurs in workplaces when the goals of nursing care are not aligned within the context of where care is delivered and the population being served. This work serves to highlight that workforce planning is not simply about recruitment processes; rather, focus is needed on integration into the cultural norms of the workplace to meet the expectations of the local workforce context and the populations they serve.

7.4 Recommendations for education, practice, policy and research

This study has proposed recommendations for consideration and identified several important questions for future research. It has highlighted several key areas that are relevant to multiple stakeholders; thus, the recommendations have been summarised under the following contexts: education, practice, policy and research (see Table 7.3).

Table 7.3. Summary of Recommendations for Education, Practice, Policy and Research

Context	Recommendations
Education	1. Review orientation programs for the development of IQRNs' knowledge and the relevant capabilities necessary for IQRNs to practice safely in the Australian healthcare system. 2. Review the integration experiences of IQRNs to inform orientation program development. 3. Investigate the use of a national model of orientation for IQRNs and evaluate criteria post-implementation. 4. Develop additional tailored in-services for IQRNs' experience and needs. 5. Enable access to postgraduate education for IQRNs. 6. Implement free English-language sessions by employers. 7. Develop reciprocal, mutual partnerships between education and practice sectors to prepare the workforce for and to educate mentor and preceptors to the special needs of IQRNs.
Practice	8. Develop reliable methods to assess IQRNs' level of competence in the workplace to use their full scope of practice, prevent deskilling and provide an opportunity to upskill in a timely manner as required. 9. Develop dedicated education and training for facilitators and mentors of IQRNs. 10. Prepare and support RNs as preceptors for IQRNs in the healthcare setting to transition effectively. 11. Develop workload models that capture non-measurable workplace cultural aspects, including orientation to work units. 12. Develop a national evidence-based program for IQRNs that supports their professional development and transition. 13. Design culturally appropriate assertiveness communication education programs for IQRNs from NESBs and CaLD backgrounds. 14. Include retention strategies in recruitment programs.
Policy	15. Review assessment requirements for IQRNs' pre-registration. 16. Review English-language assessment tools used, including fitness for purpose for applicants from selected country-of-origin groups. 17. Develop standards of practice that describe level of practice for IQRNs. 18. Explore potential to align regulatory processes between countries as a strategy to improve registration and orientation. 19. Develop a national nursing workforce policy.
Research	20. Evaluate the efficacy of orientation programs for IQRNs. 21. Evaluate the efficacy of cultural responsiveness programs. 22. Evaluate pathways to registration for IQRNs. 23. Investigate efficacy of communication skills used in multicultural teams across healthcare services in Australia. 24. Investigate clinical support models required to support IQRNs. 25. Explore factors that contribute to positive workplace environments in diverse teams in Australia. 26. Investigate the development of an orientation program that incorporates professional IQRN preceptor support.

The recommendations in Table 7.3 aim to enhance adaption processes for AQRNs and IQRNs in the Australian healthcare system by providing direction for educators, practitioners, regulators and healthcare organisations. Further research to evaluate the efficacy of orientation programs for IQRNs and specific support for IQRNs' preceptors will provide further evidence to facilitate and improve transition, adaption and integration processes and improve the retention of experienced RNs in the workforce.

7.5 Study strengths and limitations

As has been discussed in this chapter, the processes and product of this research demonstrate rigour and quality. In particular, the following key points are considered strengths of this study:

- topic is significant, relevant and contemporary to nursing workforce, regulators and healthcare organisations
- use of survey and interview methods ensured breadth and depth of data for analysis
- rigorous and meticulous application of research methods is demonstrated
- study is inclusive of three publications that have attracted attention and citations
- GT *playing the game* has been evaluated and found to be credible and original, to have resonance, and to be useful and relevant to practice.

It is widely acknowledged that all research has limitations (Creswell, 1998; Creswell & Plano Clark, 2011; Schneider, Whitehead, LoBiondo-Wood, & Haber, 2013). Reporting limitations in a study is the final step in demonstrating transparency and engendering trustworthiness in the research design and findings.

The limitations identified in this study include:

- The study was conducted in Australia only and with RNs; enrolled nurses were not included in the scope of this study.
- Recruitment processes may have resulted in over-representation of nurses who have a higher level of English-language proficiency.
- Recruitment of participants for this study via nursing organisations may have limited the pool of potential participants.

- This study was not intended to differentiate the experiences of IQRNs from specific countries or cultural or nursing education backgrounds, and the findings are therefore not specific to these nuances.

Notwithstanding these limitations, this study has implications for future nursing workforce sustainability and addresses significant gaps in knowledge to advance an understanding of integration processes, leading to relevant and implementable findings for nursing workforce sustainability.

Significantly, the findings of this study have implications for those assessing and regulating the registration of internationally qualified nurses to work in Australia and for those managing the orientation and transition of IQRNs into practice in Australia. Collectively, the findings of this study inform recommendations and areas for future research. At the time of writing, the AHPRA has called for tenders to develop an orientation program for IQRNs. The author of this study is part of a tender submission that has been shortlisted by the AHPRA at the time of the thesis submission. There are some initiatives underway that may address some of the recommendations in this study.

7.6 Conclusion

This chapter concludes the thesis. This study addressed a substantial issue to the nursing profession using a research design underpinned by GTM, which proved to be a suitable methodology to answer the research question. The findings make a significant contribution to new knowledge and a contemporary understanding of the processes that nurses undergo to adapt to new health environments and the processes that local nurses use to work with international colleagues. The dissemination of these findings aims to make a contribution to the nursing profession—particularly to nurses working in Australia. The findings aim to improve the understanding of complex and dynamic workforce environments and support initiatives to improve and inform policy direction and regulatory and assessment guidelines. Ultimately, these initiatives will ensure that the Australian public has a nursing workforce that delivers safe, quality nursing care in supportive environments. Such environments will support the retention of experienced nurses, regardless of their country of origin or where they received their first nursing qualification

Epilogue

We are one, but we are many
And from all the lands on earth we come
We share a dream and sing with one voice:
I am, you are, we are Australian
I am, you are, we are Australian.
*(Woodley & Newton, 1987)**

The purpose in undertaking any research project is to discover new knowledge or understanding of a phenomenon and to disseminate the findings. The art is in conveying the findings in a palatable way that is concise and meaningful without being superficial, and in a way that resonates with the intended audience. For me, the audience is my fellow nursing colleagues and the nursing bodies that regulate the profession.

I found it extraordinarily difficult to convey findings that were contrary to expectations—that is, when the findings indicated racism, discrimination and bullying occurring both covertly and overtly in a professional body of skilled, tertiary-educated professionals. However, I need to report what I found, framed in a way to enhance understanding, and not target or inflame any particular group of nurses, cultures, races or countries in which nurses are educated and work. It was not about singling out a particular IQRN or AQRN, but about understanding the perspectives of many. Nurses are inherently on the same page and aim to provide the best care they can in the circumstances. In Australia, nursing is highly regulated, and quality and safety are paramount.

Nurses universally work and serve diverse populations and work with people across sectors, geographic and political landscapes, yet there are significant challenges in many workplaces for nurses working together in dynamic environments. While the majority of the profession get on with it, learn the craft, play the game by the rules and are resilient, effective, hardworking, collegiate and friendly, there are some that are racist, some that are bullies and some that discriminate against fellow RNs based on where they were educated, the language they speak, their work ethic or the country they came from. Such reports were received from every area of nursing (from pre-natal to end-of-life care), in every state and territory in Australia, and from AQRNs and IQRNs who worked across a range of levels from bedside to

directors of nursing, union members and nurses in positions of power at the government level. Examining the reasons why this occurs among highly educated professionals who have specific education in effective communication was particularly disconcerting to discover. Although my intent was to synthesise and accurately convey what is said or implied, equally it was to determine what the nurses might be thinking but not saying. The most important concern for me was asking what they were not saying and working that out.

Personal reflection: What is in a name?

How does your name influence how others first perceive you? This was a question posed in one interview conducted with an IQRN from an Asian background. The participant had consented to be part of the study after seeing an *invitation to take part in a study flyer* at the facility where the participant worked. The interviewer's surname is of Chinese origin. The participant had only agreed to be interviewed because they assumed that the researcher conducting the interview was Chinese. Upon reflection, this appears to be a double-edged sword. What effect has this had on others who may similarly have assumed the researcher was from an Asian background? The effect on this study is unknown; however, given that reports of racism and discrimination are reported regularly in the literature, the influence of one's own background, cultural heritage and assumptions may influence participants' recruitment. The participant agreed to take part in the interview. However, in an endeavour to be more transparent, information on subsequent recruitment flyers included a photograph of the researcher.

Memo
Similarly, I reflected on my own assumptions, seeing a participant consent form with a non-Anglo-Saxon name and not knowing whether the participant was born in Australia, from an NESB or a CaLD background … After the initial coding, when it became apparent that RNs from an NESB or CaLD background were needed, I used theoretical sampling, and if a nurse with an Indian or non-Anglo name volunteered, they were the first participant approached, because the focus at that time was to interview more IQRNs from an NESB or CaLD background.

Reaction to the researcher's voice resulted in several comments of expecting to hear an Asian accent when participants heard the researcher speak for the first time. The researcher's

parents were European immigrants post-WWII, and while English is not the researcher's or their family's first language, the researcher received their education in Australia and has an Australian accent.

My own general practitioner trained in India and worked in the UK and in regional and rural Australia for many years before moving to a regional centre. My immediate family includes members from five continents and six different cultural backgrounds. We speak five different languages among us. I am in no way racist, yet I feel by exposing the harsh reality of these findings, I may inadvertently offend others. The lesson I have learned from hearing the stories of many is that in the synthesis of the information, there is a genuine deep and profound responsibility to accurately represent those who have given freely of their time and provided valuable personal insights into contemporary nursing practice. The diversity dividend is a magnificent contribution to any workforce; however, it requires input from all nurses, regardless of where they received their nursing education, and it is everyone's responsibility to find ways to work together in cohesive and meaningful ways. Our nursing workforce deals with people from all walks of life, sometimes at their most vulnerable moments. We aim to provide the highest level of nursing care and deliver it safely and with high levels of patient, client and consumer satisfaction while maintaining and sustaining a workforce for today, tomorrow and into a sustainable future.

Nurses are readily attracted to the profession, but retention remains a significant issue. As a profession, we need to work out the issues that detract from a positive environment so they can be addressed professionally and respectfully together with regulators, educational providers, industry partners, nursing recruitment agents and the international nursing community. Nursing is and will be a mainstay for all citizens around the world, so it is incumbent on each of us in the nursing profession to take a moment to reflect on our own contribution to the problem, or to the solution. We owe it to ourselves, to our future nursing and healthcare workforce and ultimately to the people in the communities to whom we dedicate our service.

* 'I Am Australian' (or 'We Are Australian') is a popular Australian song written in 1987 by Bruce Woodley of The Seekers and Dobe Newton of The Bushwackers.

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Appendix A: Bridging Programs for IQRN

Internationally qualified registered nurses (IQRNs) interested in working in Australia need to apply for and be registered with the Nursing and Midwifery Board of Australia (NMBA). IQRNs may also need to apply for a visa issued by the Australian Department of Immigration and Border Protection (Australian Immigration Department).

Internationally qualified applicants must meet the registration standards of their health profession which includes the English language skills registration standard and the Criminal history registration standard. Additional requirements for Nurses apply http://www.ahpra.gov.au/Registration/Registration-Process/Overseas-Practitioners.aspx

The Australian Health Practitioner Regulation Agency (AHPRA) assesses applications for registration from internationally qualified nurses on behalf of the NMBA. The NMBA is governed by the Health Practitioner Regulation National Law as in force in each state and territory and is responsible for the final decision on each application.

Immigration to Australia
ANMAC assesses the skills of internationally qualified nurses who want to migrate to Australia under the General Skilled Migration program.

Difference between ANMAC (immigration) and NMBA (registration) assessments
ANMAC takes into consideration work experience in assessing an applicant's qualifications, which is then used to determine suitability for skilled migration. Under the National Law, the NMBA can only take into account an applicant's qualifications when establishing whether their qualifications are substantially equivalent to an Australian qualification. This is why some applicants may be approved for skilled migration but do not meet the registration requirements of the NMBA.

Bridging programs are only available to internationally qualified nurses and midwives who are required by the National Board under s 53(c) of the National Law to undertake a bridging program following an assessment of their qualifications. A bridging program is a program of study approved by the NMBA that enables internationally qualified nurses and midwives who do not qualify for registration under section 53(b) of the National Law to meet the requirements under section 53(c) by completing further study and assessment against the NMBA's standards for practice. To be eligible, international applicants must be referred to a bridging program by the NMBA.

Individual education providers decide each year whether to offer a course (Board-approved program of study). The course costs are set by the education provider. These costs vary based on the course content including supervised clinical experience placements, student insurance arrangements, government subsidies and whether students are Australian citizens (Table 1).

Table 1. Approved Programs of study for internationally qualified registered nurse (Division 1) bridging programs in Australia.

Education Provider	Program Title	Approved campuses	Qualification	Program Code/ Length	Professional Placement	Cost	Entry requirements	Advanced Standing	NMBA Accreditation
Australian Centre of Further Education	Initial Registration for Overseas Nurses-	Melbourne Victoria	Non-qual award - Initial Registration	480 hours (12 weeks) The theoretical component of the program consists of 4 weeks of study. This includes	6 weeks	1. Application Fee: AUD $250 (non-refundable) this fee is	Application Requirements Documents Required to Submit the ACFE Application Form	Not stated	National Board 06/03/2013

	Registered Nurse		for Overseas Nurses-Registered Nurse	lectures, discussion, workshops and self-directed material. Simulated workshops form part of the theory component, which allows the nurse to practice a variety of common nursing interventions in a safe and non-threatening environment. Both the 4 weeks theory and 6 weeks clinical practice component of the program need to be completed within 12 weeks from the date of commencement.		required together with a completed ACFE Application Form 2. Course Fee: AUD $14,000 (inclusive materials) a. Initial Fee of $7,000 (50% deposit) is required within 7 days of receiving the Letter of Offer and Invoice from ACFE. This fee will confirm your place in the IRON Program and your Clinical Placement. b. The balance is required not later than one month prior to the start of the Course or as soon as the Applicant has been granted Visa by the Aust government.	Australian Health Practitioner Regulation Agency (AHPRA) Course participant must provide an original certified true copy of the AHPRA Letter indicating which course they have permission to complete. This letter must be Valid. (A valid letter is 12 months from the date of issue) English Language proficiency International English language Testing System (IELTS) a score of at least 7.0 in each component OR Occupational English Test (OET) a score of at least B in each component. Requirements much be achieved in a single sitting and results a valid for two years. Course participant need to provide a certified copy for enrolment. Supporting documents Please attach an up to date resume and a letter explaining the reason why you wish to enrol into the course Applicant must pass a selection interview. Additional Documents Required when accepted in the Program Applicants must provide certified copies of all relevant information of nursing registration, and other nursing courses. Police Clearance: Course Participants must provide a certified copy of a Police clearance certificate from country of origin. On shore applicants must have a current working with children check (Victoria) or interstate equivalent. Immunisation : Course Participants need to provide evidence of Immunisation for Hepatitis B, Pertussis, Diphtheria, Tetanus, Measles, Mumps Rubella, Annual Influenza vaccination and swine flu, Mantoux Clear X ray for Tuberculosis		Approval : National Board Approval 06/03/2018

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							Overseas Health Insurance: Course Participants must provide evidence of having Overseas Health Insurance prior to staring course. 2x passport-size certified photos taken within the last six (6) months		
Australian College of Nursing	Entry Program for Internationally Qualified Nurse Registered Nurse	Parramatta campus NSW	Non-award qualification Bridging & Re-entry	11 week course 200 Theoretical hours and 240 Professional Placement hours. **Course content** We deliver a comprehensive, contemporary and clinically relevant course. The course will cover: • the Australian healthcare system • ethics in nursing • professional practice in Australia • nursing and the law • patient safety and risk management • medication management • critical thinking, inquiry and research • contemporary indigenous health • effective communication for health care professionals • reflective practice • clinical practice in acute care • healthcare across the lifespan from child and community	6 weeks clinical placement 240 hours. Shifts will vary from morning, afternoon and night duty ACN does not organise participant accommodation	Fees schedule $250.00 non-refundable application fee (will be deducted from final payment) $1000.00 non-refundable acceptance fee (payable when placement is accepted) $10,250.00 final payment due 3 week's prior to program commencement Total cost $11,500.00	Participants must be referred to this course by the Australian Health Practitioner Registration Agency (AHPRA)	Not stated	National Board Approval Start Date: 10/12/2013 National Board Approval End Date: 10/12/2018

				through to aged care.					
Deakin University	Initial Registration of Overseas Nurses - Registered Nurse	Burwood Melbourne Victoria	Non-qual award - Initial Registration Course for Division 1 Overseas Registered Nurses	CRICOS Course code 062983J Deakin code: H011 Ten weeks (6 weeks academic & 4 week clinical). Units offered: HNN021 Nursing Practice in Australia HNN026 Legal Ethical and Contemporary Issues in Australian Nursing Practice HNN025 Clinical Practicum	4 weeks	This is a full fee paying program. International applicants must contact Deakin International directly for details of course fees	**Entry requirements - general** International students must meet academic admission requirements as well as English language requirements to be considered for entry. Applicants must: • have obtained approval from the AHPRA or the Nursing and Midwifery Board of Australia to participate in the course; and • be permanent Australian residents and hold, or be eligible to hold, a current Visa (contact your nearest Australian Diplomatic Mission for advice); or • be overseas qualified nurses; and • have proof of achievement of an overall 'B' pass or above in all four sections in the Occupational English Test (OET), achieved in one sitting, or an International English Language Testing System (IELTS) with a minimum of 7 in all four components (Reading; Listening: Writing and Speaking obtained in one sitting for the test). Please also check http://www.ahpra.gov.au/Registration/Registration-Process/Registration-Requirements.aspx for English language requirements following completion of the course.	Not stated	National Board Approval Start Date: 08/03/2013 National Board Approval End Date: 27/08/2020
Education, Training and Employment Australia	Initial Registration Course for Division 1	Heidelberg VIC, Canningvale WA,	Non-qual award - Initial Registration	Code: IRON1A 12 weeks (4 weeks theory & 8 Weeks Professional experience placement)	8 weeks. PEP are organised in a variety of hospitals in both	$150 non-refundable (IRON program)	The course, also known as IRON or Bridging program, is accessible to all overseas Qualified Nurses wishing to nurse in Australia who have been	Not stated	National Board Approval Start Date: 14/04/2014

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	Overseas Registered Nurses (CRICOS approved)	Adelaide SA, Eveleigh, NSW	Course for Division 1 Overseas Registered Nurses	Topics include: Medication Calculations IVT OH&S and Manual Handling Infection Control and Aseptic Technique NMBA Registered Nurse Standards for Practice & Effective Communication Planning Nursing Care Ethics in Health Care, Professional codes Physical Examination Context of Practice, Delegation and Supervision Pain Management and Wound Care Management of Information in Health Care, Pharmacology in Australia Nursing Professional Organisations and Regulations, Recruitment and Interview Skills The Australian Legal System and Nursing Diabetes and Medications Health Care in Australia Cardiovascular Disorders, ECG and Medications Basic Life Support Respiratory Disorders and Medications Australian Charter of Health Care Rights: Autonomy, Privacy and Confidentiality Gastrointestinal Disorders and Urology Culture Mental Healthcare in Australia Teamwork and Conflict Resolution, Multidisciplinary Teams	metropolitan and rural centres within Australia. Students are assisted with finding suitable accommodation near the Hospital to minimise travelling. This clinical placement must be in an acute care setting, for all competencies to be achieved. Clinical supervision is guaranteed at all times.	$17000.00 Course fee	recommended by the Australian Health Practitioner Regulation Agency for eligibility. A letter from the Australian Health Practitioner Regulation Agency (www.ahpra.gov.au) confirming eligibility to complete an Initial Registration course, including any requirements as stated within the letter from the Australian Health Practitioner Regulation Agency.		National Board Approval End Date: 01/02/2018

				Aged Care Funding, Dementia and Delirium, Elder Abuse Research in Nursing, Health Promotion and Client Education Palliative Care, Oncology, Grief and Loss.					
Institute of Health and Nursing Australia (IHNA)	Initial Registration for Overseas Registered Nurses	Melbourne Heidelberg Campus Perth Campus	Initial Registration for Overseas Registered Nurses	Code: BPOQN 360 hours total The course consists of 9 weeks full time study, comprising: 1. 4 weeks: Theory sessions at campus 2. 5 weeks: Professional experience placement sessions at clinical facilities This program consists of a theory component of 160 hours and an acute care Professional experience placement of 200 hours. The program is divided into 4 learning areas: 1. Professional Issues in Clinical Practice • The Australian Health Care environment • Professional bodies, codes, guidelines & legal implications in nursing • Cultural & Ethical awareness in nursing • Contemporary Issues in Nursing practice • Indigenous health and culture 2. Comprehensive Health Assessment • Occupational Health & Safety • Communication & Documentation in Nursing • Pharmacology in Nursing • Complex Nursing Care	5 weeks All Theoretical Assessments must be passed before the Professional experience placement component can be commenced.	Not stated	All candidates are required to: 1. Provide a letter from AHPRA confirming eligibility to undertake the IRON course. 2. Be successful at IHNA selection process. 3. Appropriate reference checks. The application process involves 5 steps: application, interview, offer letter, payment and confirmation of admission. Applicants must successfully complete each stage in order to enrol.	Not stated	National Board Approval Start Date: 28/02/2013 National Board Approval End Date: 30/11/2017

				3. Evidence Based Nursing Care • Introducing evidence into nursing practice • Concepts and challenges in patient care • Mental health • Nursing care of the older adult • Leadership & Management in nursing 4. Professional experience Placement					
La Trobe University	Initial Registration for Overseas Nurses - Registered Nurse	Bendigo Victoria	Initial Registration for Overseas Nurses - Registered Nurse	13 weeks 80 hours of interactive workshops 20 hours of simulation and clinical consolidation in clinical learning units 220 hours of student-directed learning and assessment activities up to 400 hours of supervised professional clinical experience practicum.	Up to 400 hours	Course fee for 2016 is AUD$12,750.	Require current referral letter from AHPRA (valid until the end of the program) English language proficiency: an IELTS (Academic) score of 7.0 overall with at least 7.0 in all bands, or OET with A or B only in each of the four components current registration as nurse in a country other than Australia (valid until the end of the program).	Not stated	National Board Approval Start Date: 25/07/2014 National Board Approval End Date: 25/07/2019
Lonsdale Institute	Initial Registration of Overseas Nurses (RN)	Myrtleford, VIC	Non-qual award - Initial Registration Course for Division 1 Overseas Registered Nurses	Three months The program is a combination of education delivery in a classroom and practical application in a clinical placement delivered 40 hours per week over a period of 12 weeks. 3 week study program that consists of lectures, tutorials, guest speakers, guided research and online tutorial and assessment. 7 Core Units • Nursing in a legal and ethical environment in Australia • Australian health care continuous improvement practices • Person centred care	9 weeks Entry into Clinical Placement Applicants must provide evidence that their vaccination history is complete and appropriate for a health/hospital setting. This includes vaccination against Hepatitis B, Tuberculosis, Influenza, MMR (Measles, Mumps and Rubella), Chicken Pox and Whooping Cough. Students without a current	Not stated Contact Lonsdale Institute on + (61 3) 9639 0543 or via email at iron@lonsdaleinstitute.vic.edu.au to ask about our current pricing structure.	AHPRA Approval Letter •CV •IELTS results •Copy of passport (ID page) •Recommendation letters You must be 18 years of age or over and provide a letter from AHPRA confirming your eligibility to undertake an approved bridging program, such as our IRON program, which must have been dated within the previous 2 years. In addition to these entry requirements, prospective students will be interviewed by phone, Skype or face to face before being issued with a letter of offer.	Not stated	National Board Approval Start Date: 06/02/2013 National Board Approval End Date: 06/02/2018

				• Interpersonal relationships in Australian health care • Cultural diversity in health care • Technology and equipment in Australian nursing practices • Australian risk management in nursing In the fourth week participants are introduced to an allocated workplace with a registered work placement provider for a 9 week period.	immunisation will not be able to undertake clinical placement. In addition, the Victorian Department of Health requires all health care staff, students to have a valid National Police Record Check while working within the health care industry.				
Monash University	Internationally Qualified Nurse (Registered Nurse)	Clayton Victoria	Initial Registration for Overseas Nurses (Registered Nurse)	12 weeks The course comprises seven modules Module 1 - The Context of Health Care in Australia (online) Module 2 - Australian Health Care (online) Module 3 - Australian Legal System (online) Module 4 - Regulation of Nursing in Australia (online) Module 5 - Safety in Health Care in Australia (online) Module 6 - Intensive week (on Monash campus) Module 7 - Clinical practicum (6 weeks)	6 weeks	The cost of the course in 2017 is AUD$14,500, which covers course tuition and clinical placement. Participants in the course must meet their own travel costs, accommodation costs, daily living costs and uniform costs for clinical placement.	Applicants must meet the following criteria to be considered for the IQN course: be overseas qualified nurses with a qualification that is equivalent to that required of an degree qualified Australian trained registered nurse; applicants must apply for overseas qualified nurse registration to AHPRA - if AHPRA judges that the applicant meets the criteria for registration they will issue a letter advising that the applicant will be eligible for registration after completion of bridging program for internationally qualified nurses - this letter is required to undertake the IQN course; meet the current Nursing and Midwifery Board of Australia English language skills registration standard (nursing and midwifery). The Registration standard document can be downloaded from the AHPRA website; have practised as a registered nurse in an acute care ward for at least one year within the 5 years prior to the application; have current Police and Working with Children checks regarding their suitability	Not stated	National Board Approval Start Date: 13/03/2014 National Board Approval End Date: 13/03/2019

							to undertake such placements; (obtained after arrival in Australia, further information provided on application) and obtain relevant vaccinations and infectious disease screening tests prior to clinical placements (information provided on application).		
Southern Cross University	The Graduate Certificate of Australian Nursing (EPIQ) EPIQ - Education Program for Internationally Qualified Nurses	Qld	Graduate Certificate in Australian Nursing	Code: 1007304 12 weeks NRS81001 - Nursing in the Australian Context NRS81002 - Professional Practices NRS82005 - Transformative Clinical Practices (Double weighted unit)	8 weeks Required to have a working with children check and National Police Certificate	**Fees 2017** $3,330 per unit This is an equivalent four unit course.	Applicants for admission must have a letter of determination from the Australian Health Practitioner Regulation Agency [AHPRA].	No Advanced Standing will be granted for any part of this course.	National Board Approval Start Date: 02/03/2016 National Board Approval End Date: 02/03/2021
University of South Australia	Graduate Certificate in Nursing (Bridging and Re-Entry)	Adelaide - City East SA	Graduate Certificate in Nursing (Bridging and Re-Entry)	Code: ICNB Course name Professional Issues and Nursing Practice in Australia NURS 5155 (9 units) Transition to Registered Nurse Practice in Australia NURS 5156 (9 units) The professional and nursing practice course covers theory and practice topics including the healthcare and legal systems in Australia, nursing ethics, the nursing process, physical examination, standard precautions, alternative health modalities, mental health care issues, primary health care, Aboriginal health, aged care, nursing research and professional communication between nurses, patients and workplace health professionals. Nursing theory also covers pharmacological	0.5 years full time (24 weeks)	$AU 25,400 per 1.0 EFTSL† for students enrolled in 2017 † This is based on the total number of units for this program where one EFTSL is expressed as 36 units	The entry requirements for internationally educated nurses are certified evidence of : Registration with the relevant Nurse Registration Authority in own country or place of residence; and A minimum 4 year Bachelor of Nursing degree from a recognised institution equivalent to the standard of registered nurse preparation in Australia (AQF level 7); and A minimum of 2 years work experience with 12 months recent practice (within the last 2 years) as a Registered Nurse in country of practice, evidenced by a certified employment statement dated in the last 6 months; and A letter of approval from the Australian Health Professional Regulation Agency (AHPRA) on behalf of the Nursing and Midwifery Board of Australia (NMBA) to undertake a NMBA approved bridging program. The referral must be current for the duration of the program to be undertaken by the applicant.	Not stated	National Board Approval Start Date: 07/07/2016 National Board Approval End Date: 07/07/2021

				principles, respiratory, cardiac, neurological, endocrine, urinary/renal, gastrointestinal and musculoskeletal systems. The eight week supervised clinical practicum focuses on developing competencies for registration and incorporates professional communication skills, mandatory skills of manual handling, CPR, medication calculations, and an eight week placement in hospital setting.			The entry requirement for Australian educated nurses is: Evidence of prior registration as a nurse with a Nurse Registration Authority in Australia within the last 10 years.		

Retrieved from http://www.ahpra.gov.au/Education/Approved-Programs-of-Study/Programs-of-Study-Terms.aspx

(NMBA, 2015)

Appendix B: Informed Consent Form for Participant Interview

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Appendix C: Informed Consent Form for Focus Group

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has been removed

Appendix D: Online Survey Questions

Welcome to the survey.

Ylona Chun Tie is a registered nurse conducting research on nurse workforce issues relevant to the Australian context.

Australian qualified registered nurses and internationally qualified registered nurses are invited to complete this survey to voice their opinions and share their experiences of working together in the Australian healthcare system. The survey should only take a little of your time and all survey responses will remain anonymous.

Your answers to the survey questions will help inform the direction of vital research into Australia's nursing workforce. A participant information sheet is provided on the following page detailing the study.

Information sheet for participants

PROJECT TITLE: Working together: Internationally qualified registered nurses (IQRNs) in the Australian healthcare system.

Ms Ylona Chun Tie is conducting the study for a PhD at James Cook University, Australia. The aim of this study is to explore the integration of IQRNs in the Australian healthcare system and to develop a theory that explains this process. The study will produce recommendations that aim to improve the quality of the work environment for RNs in Australia.

You are being asked to participate because you are a registered nurse (RN) who has experience working with internationally qualified RNs, a RN who received your first nursing qualification/s overseas, or a RN who has worked as a nurse internationally.

Should you agree to participate in the survey, you will not be asked to provide any identifying information with your responses. The survey will ask you about your experiences working in the Australian healthcare system and should take no more than 10-20 minutes to complete. You may choose to answer all or some of the questions. Submitting the survey implies your consent to participate.

On completion of the survey, you will be invited to contact the researcher for possible inclusion in an interview and/or focus group.

Any details you provide for this purpose will not be linked to your responses in the survey. There is no obligation to participate in an interview and/or focus group should the researcher subsequently contact you. The data from the study will be used in research publications and reports. You will not be identified in any way in these publications.

Taking part in this study is completely voluntary. You can stop taking part at any time without explanation or prejudice and can withdraw any unprocessed data you have provided.

If you have any questions about the study, please contact:

Principal Investigator:
Ms Ylona Chun Tie, RN BNSc PGCertNSc(IntCare) MAdvNPrac GCertHlthProfEd C.dec
Nursing, Midwifery and Nutrition,
College of Healthcare Sciences
James Cook University
Email: ylona.chuntie@jcu.edu.au

Principal Supervisor:
Professor Melanie Birks
Head, Nursing, Midwifery and Nutrition
College of Healthcare Sciences
James Cook University
Email: melanie.birks@jcu.edu.au

If you have any concerns regarding the ethical conduct of the study, please quote HREC ID 6171 and contact:
Human Ethics, Research Office
James Cook University, Townsville, Qld, 4811
Phone: (07) 4781 5011 (ethics@jcu.edu.au)

Bu submitting the survey you agree you are a registered nurse, have read the participant information sheet and consent to participate.

Q1: What is the postcode of your usual place of *residence*?

Q2: Which category below includes your age?

- ◯ 18-24 ◯ 25-34 ◯ 35-44 ◯ 45-54 ◯ 55-64 ◯ 65-74 ◯ 75 or older

Q3: What is your gender?

- ◯ Female
- ◯ Male
- ◯ Other (please specify)

Q4: What nursing qualifications do you have? Select all that apply.

- ☐ Hospital Certificate
- ☐ Diploma of Nursing
- ☐ Bachelor Degree
- ☐ Post Graduate Certificate/Diploma
- ☐ Master Degree
- ☐ Doctoral Degree
- ☐ Other (please specify)

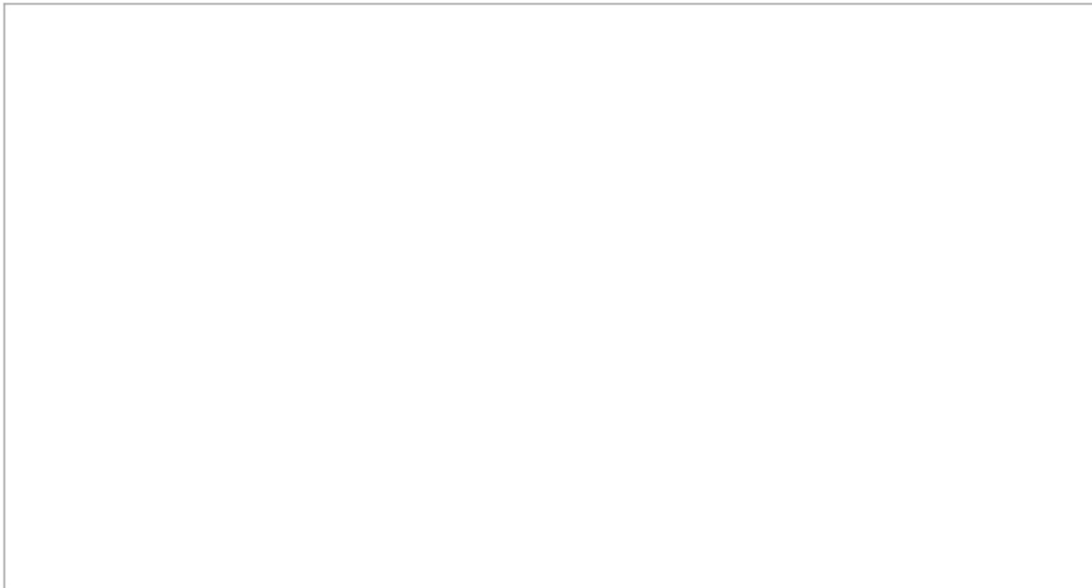
Q5: Where did you obtain your initial qualification that qualified you as a registered nurse?

- ◯ Australia
- ◯ New Zealand
- ◯ United Kingdom
- ◯ Germany
- ◯ Italy
- ◯ India
- ◯ Sri Lanka
- ◯ China
- ◯ Phillippines
- ◯ Malaysia
- ◯ Vietnam
- ◯ Middle East
- ◯ South Africa
- ◯ Zimbabwe
- ◯ Oceania
- ◯ United States of America
- ◯ Canada
- ◯ South America
- ◯ Other (please specify)

These next few questions are, by far, the most important questions in this survey. Please take this opportunity to tell us what you think.

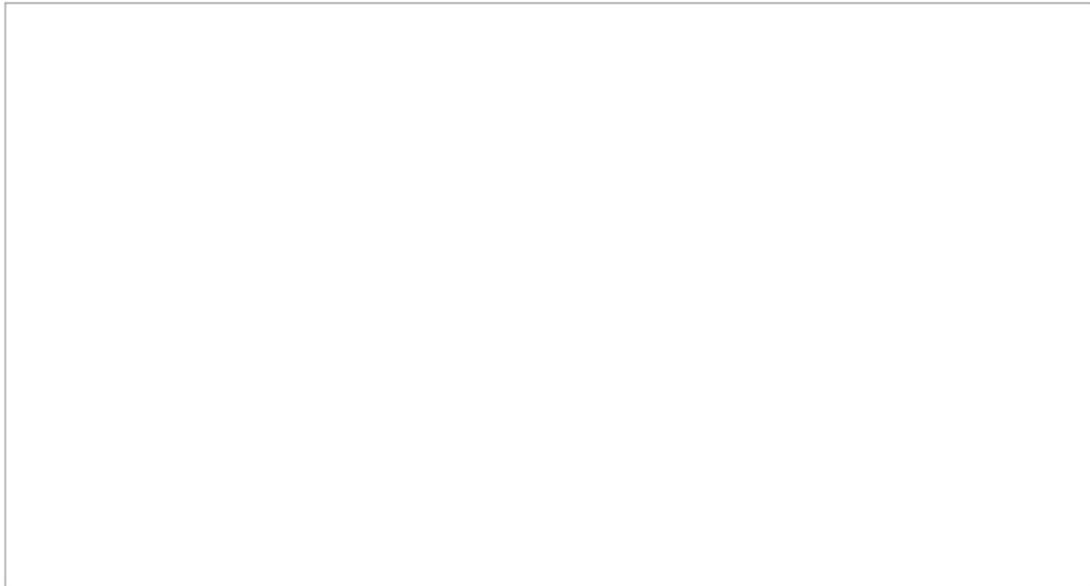
Q6: What factors do you think contribute to the integration of internationally qualified registered nurses in the Australian healthcare system?

Q6a: What examples have you observed from your experience?



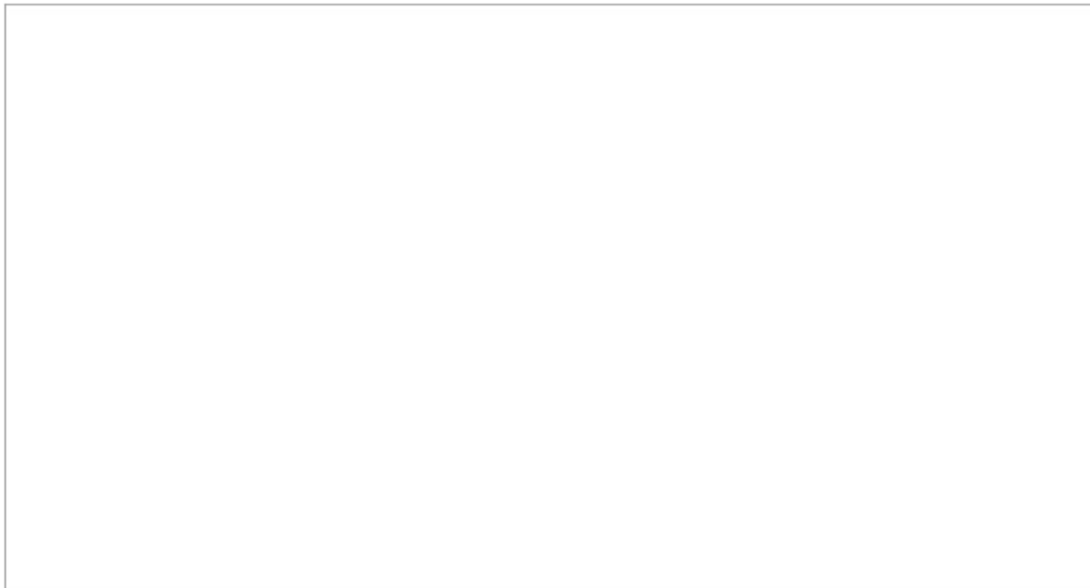
Q7: What factors if any impede the integration of internationally qualified registered nurses in the Australian healthcare system?

Q7a: What examples have you observed from your experience?



Q8: In your experience what can be done to better facilitate the integration of internationally qualified registered nurses in the Australian healthcare system?

Q9: Please add any further comments or information you would like to contribute about the integration of internationally qualified registered nurses in the Australian healthcare system.



The remaining questions are mostly multiple choice questions.

Q10: What is the postcode of your usual place of *work*?

Q11: Which one of the following best describes your current position?

- Registered Nurse
- Clinical Nurse
- Clinical Nurse Consultant
- Registered Midwife
- Registered Nurse/Registered Midwife
- Nurse Manager
- Nursing Clinical Director/Director of Nursing/Senior Nurse Manager
- Health and Welfare Service Manager
- Nurse Researcher
- Nurse Academic
- Nurse Educator
- Nurse Practitioner
- Other (please specify)

Q12: What is your principle area of nursing practice?

- Aged Care
- Cardiac
- Coronary Care
- Child and Maternal Health
- Clinical Educator
- Clinical Practice
- Community Health
- Critical Care
- Developmental Disability
- Drug and Alcohol
- Endoscopy
- Emergency
- Education
- Health Promotion
- Intensive Care
- Management
- Medical
- Mixed Medical/Surgical
- Mental Health
- Maternity Care
- Neurology
- Paediatrics
- Peri-operative/Recovery
- General Practice
- Operating Theatre
- Orthopaedics
- Palliative Care
- Rehabilitation and/or Disability
- Renal
- Remote area nursing
- Research
- Rural
- Self-employed
- Surgical
- Other (please specify)

Q13: How many years have you worked in this area of practice?

- < 1
- 1- 5
- 6 -10
- 11- 20
- 21- 30
- 31- 40
- > 40

Q14: Which sector(s) are you currently employed in? Select all that apply.

- Private Sector
- Public Sector
- Both Public and Private
- Vocational Training College/TAFE
- Other (please specify)
- University
- Non-Government Organisation (NGO)
- Not currently working as a registered nurse in Australia

Q 15: Which of the following best describes your current employment status?

- Permanent Full time (more than 30hrs/week)
- Permanent Part time (less than 30 hours/week)
- Casual/Agency
- Retired/Not working
- Other (please specify)

Q16: In years, how long have you practiced as a registered nurse in Australia?

- < 1
- 1-5
- 6-10
- 11-20
- 21-30
- 31-40
- > 40

Q17: Have you worked as a registered nurse in a country other than Australia?

- ◯ No
- ◯ Yes

A few more questions.

Q18: Which country or countries have you worked in as a registered nurse? Select all that apply.

- ☐ United Kingdom
- ☐ New Zealand
- ☐ United States of America
- ☐ India
- ☐ Philippines
- ☐ China
- ☐ Vietnam
- ☐ Other (please specify)

Q19: How many years in total did you work overseas as a registered nurse?

- ○ < 1
- ○ 1 - 5
- ○ 6 -10
- ○ 11- 20
- ○ 21- 30
- ○ 31- 40
- ○ > 40

Q20: What is your country of birth?

- ○ Australia
- ○ Canada
- ○ China
- ○ Egypt
- ○ Germany
- ○ India
- ○ Ireland
- ○ Italy
- ○ Korea
- ○ Malaysia
- ○ New Zealand
- ○ Philippines
- ○ Singapore
- ○ South Africa
- ○ United Kingdom
- ○ United States
- ○ Vietnam
- ○ Zimbabwe
- ○ Other (please specify)

Q21: Is English your first language?

- ○ Yes
- ○ No

Q22: Do you speak a language other than English?

- ◯ Yes
- ◯ No

Last few questions.

Q23: Which language/s other than English do you speak? Select all that apply.

- [ ] Arabic
- [ ] Cantonese
- [ ] Filipino
- [ ] German
- [ ] Hindi
- [ ] Italian
- [ ] Lebanese
- [ ] Mandarin
- [ ] Portuguese
- [ ] Sinhalese
- [ ] Spanish
- [ ] Turkish
- [ ] Vietnamese
- [ ] Other (please list all languages spoken)

Q24: Which ethnicity do you identify with?

- [ ] Caucasian
- [ ] Australian Aboriginal and/or Torres St Islander
- [ ] Arab or Middle Eastern
- [ ] Asian
- [ ] Black or African American
- [ ] Hispanic or Latino
- [ ] Indian
- [ ] Pacific Islander
- [ ] Multiracial
- [ ] Other (please specify)

Q25: Are you an Australian citizen/permanent resident?

- ○ Yes
- ○ No

Almost done.

Q26: Which of the following Australian visas has been issued to you?

- ◯ 309 Partner (Off shore)
- ◯ 401(Temporary long stay)
- ◯ 402 (Training and research)
- ◯ 417 (Working holiday)
- ◯ 422 (Medical practitioner)
- ◯ 444 (Temporary special category)
- ◯ 457 (Temporary work skilled)
- ◯ 462 (Work and holiday)
- ◯ 485 (Temporary graduate)
- ◯ 489 (Skilled regional provisional)
- ◯ 572 (Vocational education and training sector)
- ◯ 574 (Higher education sector)
- ◯ 820 Partner (Onshore)
- ◯ Other (please specify)

Q27: Please add anything else you would like to share about your experiences working with or as an internationally qualified nurse in the Australian healthcare system.

Q28: List any questions you would like the research team to consider in future research on the integration of registered nurses in the healthcare system.

WE'D LOVE TO HEAR MORE FROM YOU

You are invited to participate in an interview or focus group to further discuss the integration of international qualified nurses in the Australian healthcare system.

If you agree to participate in an interview and/or focus group, these sessions should take no longer than an hour of your time. The focus group and/or individual interview, with your consent, will be audio-taped for transcription. The interviews and focus groups will be conducted at a time and place convenient for you. Interviews may be conducted in person, by telephone or by videoconferencing (e.g. Skype). The researcher, with your consent, may contact you following the interview or focus group should further information or clarification be required.

Any details you provide will not be linked to your responses in this survey.

If you would like to be contacted for possible inclusion in an interview and/or focus group please email:

ylona.chuntie@jcu.edu.au

Please share the survey link with any nurses who may be interested in nurse workforce issues involving internationally qualified nurses.

https://www.surveymonkey.com/r/IQRNs

Thank you for completing this survey and the information you have shared.

Your time is very much appreciated.

You have reached the end of the survey.

Thank you for your time and contribution.

Your responses have been recorded.

Appendix E: Participant Information Sheet

INFORMATION SHEET FOR PARTICIPANTS

PROJECT TITLE: Working together: Internationally qualified registered nurses (IQRNs) in the Australian health care system.

You are invited to take part in a research project about internationally qualified RNs working in the Australian health care system.

You may be a registered nurse (RN) who received your nursing qualification/s overseas, a RN who has experience working with internationally qualified RNs, or you may be a RN who has worked as a nurse internationally.

Ms Ylona Chun Tie is conducting the study for a PhD at James Cook University, Australia. The aim of this study is to explore the integration of IQRNs in the Australian health care system and to develop a theory that explains this process. The study will produce recommendations that aim to improve the quality of the work environment for RNs in Australia.

Should you agree to participate in the survey, you will not be asked to provide any identifying information with your responses. The survey will ask you about your experiences working in the Australian health care system and should take no more than 20 minutes to complete. You may choose to answer all or some of the questions. Submitting the survey implies your consent to participate.

On completion of the survey, you will be invited to contact the researcher for possible inclusion in an interview and/or focus group. Any details you provide for this purpose will not be linked to your responses in the survey. There is no obligation to participate in an interview and/or focus group should the researcher subsequently contact you.

If you agree to participate in an interview and/or focus group, these sessions should take between 1-2 hours of your time. The focus group and/or individual interview, with your consent, will be audio-taped for transcription. The interviews and focus groups will be conducted at a time and place convenient for you. Interviews may be conducted in person, by telephone or by videoconferencing (e.g. Skype). The researcher, with your consent, may contact you following the interview or focus group should further information or clarification be required.

All information and responses will be held in strict confidence and will only be accessed by the researcher, her supervisors, and a professional transcriber employed for this purpose. Please note that confidentiality cannot be assured in focus groups. The data from the study will be used in research publications and reports. You will not be identified in any way in these publications.

Taking part in this study is completely voluntary. You can stop taking part at any time without explanation or prejudice and can withdraw any unprocessed data you have provided.

If you have any questions about the study, please contact:

Principal Investigator:
Ms Ylona Chun Tie, RN BNSc PGCertNSc(IntCare) MAdvNPrac GCertHlthProfEd
Nursing, Midwifery and Nutrition,
College of Healthcare Sciences
James Cook University
Phone:
Email: ylona.chuntie@jcu.edu.au

Principal Supervisor:
Professor Melanie Birks
Nursing, Midwifery and Nutrition
College of Healthcare Sciences
James Cook University
Phone:
Email: melanie.birks@jcu.edu.au

If you have any concerns regarding the ethical conduct of the study, please contact:
Human Ethics, Research Office
James Cook University, Townsville, Qld, 4811
Phone: (07) 4781 5011 (ethics@jcu.edu.au)

Cairns - Townsville - Brisbane –Singapore
CRICOS Provider Code 00117J

Appendix F: Ethics Approval HREC

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Appendix G: Ethics Amendment Approval HREC

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Appendix H: Dissemination of Research Findings

Conference presentations

2018

National Forum. Australian College of Nursing. Oral presentation. *The strength of diversity in Australia's nursing workforce: Contribution of internationally qualified nurses*, 28–30 August. Gold Coast, Qld, Australia.

Sigma Theta Tau International's 29th International Nursing Research Congress. Oral presentation. *Leadership in culturally diverse nursing teams: Mitigating adverse team dynamics.* 19–23 July, Melbourne, Vic, Australia.

12th Biennial Conference of the Global Network of WHO Collaborating Centres for Nursing and Midwifery, Poster presentation. *Sustainable Development Goals: The contribution of internationally qualified registered nurses, 18–19 July, Cairns, Qld, Australia.*

16th Qualitative Methods Conference, Oral presentation. *Theoretical Sampling Online Survey Data in a Grounded Theory Study: An Exemplar*, 1–3 May, Banff, Alberta, Canada.

2017

JCU Science Research Festival: Poster presentation. *The contribution of internationally qualified nurses.* 7–8 September. Townsville, Qld, Australia.

Townsville Hospital Research Showcase: Poster presentation. Building an exceptional workforce. 4–6 September, Townsville, Qld, Australia.

ACN conference. Oral presentation. *Making change happen within a diverse workforce: Hearing the voices of nurses*. 21–23 August, Sydney, NSW, Australia.

International Council of Nurses (ICN) Congress, Oral Presentation A review of the impact of nurse migration on the Australian nursing workforce. 27 May–1 June, Barcelona, Spain.

206

14th National Rural Health Conference (NRHC), Delegate. Workshop facilitator NRHC Rural and remote workforce sustainability, 26–29 April, Cairns, Qld, Australia.

2016

12th Congress of the World Federation of Critical Care Nurses *incorporating the 17th Annual Institute of Continuing Education Conference—Brisbane, Queensland, Australia. Delegate*.

2015

14th International Qualitative Methods Conference, Oral presentation. *Working Together: The Integration of Internationally Qualified Registered Nurses into the Australian Healthcare System*. Melbourne, Victoria, Australia.

14th International Qualitative Methods Conference, Poster presentation. *Learning from Each Other: Cross Cultural Philosophy*, Melbourne, Victoria, Australia.

2014

The Tenth International Congress of Qualitative Inquiry (ICQI 2014), Oral presentation. *Practical Philosophy*. University of Illinois, Urbana, Champaign, USA.

Radio interview

2017—Radio Interview with journalist Krystal Gordon from ABC news. Topic—*Recognising internationally qualified nurses*. Interview aired ABC am. 21 August 2017.

Industry engagement

Expert Panel Member

2015—Member of the RN expert panel for the development of an assessment framework as part of the Nursing and Midwifery Board of Australia (NMBA) initiative *Outcomes-based assessment of international qualified nurses and midwives (IQNMs) competence to practice.*