

**Transitioning difficulties of overseas trained
nurses in New Zealand.**

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What difficulties are experienced by
overseas trained nurses in their transition
to the NZ practice context?

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ABSTRACT

Registered Nurses (RNs) who have trained overseas have become an important part of the New Zealand (NZ) workforce. Some 21% of RNs working in NZ were trained overseas. Internationally, NZ has the highest percentage of migrant nurses (Nursing Council of New Zealand, 2011; Wright, 2009). Overseas research recommends efforts be made to enhance adjustment of nurses from other cultures to work and life in a new country (Aitken, Buchan, Sochalski, Nichols, & Powell, 2004; Buchan, Naccarella, & Brooks, 2011; North, 2010; Woodbridge & Bland, 2010; Yi & Jezewski, 2000). Little research has been conducted in this area within NZ.

This study will explore the experience of overseas trained nurses (OTNs) who have migrated to NZ within the last two years. It will focus on OTNs lived experience and explore any difficulties that they may have experienced when transitioning into the NZ health system. An exploratory qualitative descriptive study will guide the research.

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ATTESTATION of AUTHORSHIP

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

Signed:

Deborah Hogan

ETHICS APPROVAL

The application for ethical approval to AUTECH – AUT's Ethics Committee was completed in June 2013. The ethics application was referred to the AUT University Ethics Committee.

Ethical approval was granted on 1st July 2013 by the AUT University Ethics Committee.

Reference: 13/129 (Appendix: I)

LIST of ABBREVIATIONS

CNM	- Charge Nurse Manager.
DHB	- District Health Board
OTN	- Overseas Trained Nurse(s)
RN	- Registered Nurse
NZ-RN	- New Zealand Registered Nurse
AUT	- Auckland University Technology
WDHB	Waitemata District Health Board

CHAPTER ONE: THE RESEARCH CONTEXT

The aim of the study is to describe the experience of overseas trained nurses (OTNs) transitioning into the New Zealand (NZ) health system. It is hoped this exploration of OTNs experience will lead to the identification of future requirements for orientation and implications for education and support within the NZ context and more specifically within our district health board (DHB). Exploring the nurses experiences through personal narratives will contribute to a deeper understanding of the challenges and difficulties OTNs may have undergone when transitioning to the NZ context. It will also provide the researcher with a better understanding of the nursing context within the OTNs country of origin.

Researchers Position

I am a Charge Nurse Manager working at one of the largest DHBs in NZ. Over the last 7 years I have been actively involved in recruitment of staff. This, in itself, leads to many challenges: getting the right skill mix, and ensuring that newly appointed staff “fit” within the existing team. While recent emphasis has been on appointing new graduates, due to the natural attrition of nursing staff, there are many times when vacancies arise during the year and appointments are necessary outside of the new graduate programme start dates. The requirements may also be for an experienced nurse rather than employing a new graduate. My experience has shown, the majority of applicants who apply for these vacancies are overseas trained nurses, many of whom have no NZ experience. Once appointed, I have found OTNs require an extended period of orientation beyond the 10 days currently funded by the DHB. In my role as CNM, I need to ensure patients receive safe, quality patient care, hence the necessity for all nurses to be competent and compassionate.

During my post graduate studies, I have had the opportunity to focus on many elements that are related to the migration of nurses, which has led me to this point. I have a keen interest in ensuring that once OTNs are appointed, that their orientation phase and subsequent settling in period is beneficial to not only the new employee, but also to patients. By undertaking this research, it is my goal to better understand the requirements of OTNs in an endeavour to provide safe, quality patient care for patients.

Significance of Research

OTNs are an integral part of the NZ workforce. There is little research, however, into difficulties/challenges experienced by OTNs when transitioning into the NZ hospital setting (Woodbridge & Bland, 2010). Given the limited amount of research within NZ, utilising an exploratory descriptive study with true reflective narratives to be analysed that are NZ in context will assist on expanding on the current literature. As future decisions are made, in relation to sustaining a workforce that delivers safe, quality care, the findings from this research will be useful for other health professionals when employing OTNs, to ensure that their practice development is adequately addressed.

Research Approach

This is a small study, being a practice project of 60 points. My primary aim was to listen to the stories of a small group of nurses who have been in employment between 6 months and 2 years within WDHB. The methodological approach is exploratory qualitative descriptive, seeking to reveal themes from which discussion and recommendations can be drawn.

Background

Nursing shortages are just one of the many challenges health professionals face each day. The demand for nurses has increased due to the ageing population, increased patient involvement and rapid progression of technologies, coupled with an aging nursing workforce looking towards retirement or the need to reduce their hours (Barnett, Namasivayam, & Narudin, 2010; North, 2010; Walker, 2009). A range of measures can be taken to assist in relieving some of the pressure from reduced nursing numbers. Commonly, these measures are focused on increasing the recruitment and retention of the workforce either by increasing student nursing numbers, or by active recruitment from overseas. The nursing workforce in NZ has, since the late 1980s, become reliant on migrant nurses (North, 2010). There are many influences and considerations that have brought the nursing workforce to this point; these will be discussed in more detail below.

The Impact of New Zealand Health Reforms on Nursing

During the 1990s, NZ underwent a series of health reforms and restructuring that not only impacted on the quality of health care but also greatly affected the nursing workforce (North, 2010). Kaelin (2011) believes that decisions made in policy during the 1980s-1990s resulted in making nursing less attractive to future recruitment, through imposing budget cuts on health.

The impact on staff, in particular nursing, is not always taken into account when restructuring. As the nursing workforce is the largest group of employees within health, it was at the core of the effects of these changes (Duffield, Kearin, Johnston, & Leonard, 2007). As a consequence many NZ trained RNs sought employment overseas, predominately in the United Kingdom and Australia, as morale dropped and the negative impacts of restructuring took its toll (North, 2007).

Many nurses also left the profession over that period and embarked on other occupations.

The consequence was catastrophic for the profession. With a reduced nursing workforce, there was no other alternative but to rely on recruiting nurses from overseas (Carryer, Diers, & Wilson, 2010; North, 2010).

The numbers of OTNs registering in New Zealand are increasing each year growing from 21% of the overall nursing workforce in 2010/2011 to 24% in 2011/2012 (O'Connor & Stoddart, 2013; O'Connor & Manchester, 2012). Two of the last five years has seen the number of OTNs exceed the number of NZ-RN's registering (O'Connor & Stoddart, 2013). In 2010/2011 the registrations were almost equal with 49% of new registrations, which were from OTNs (O'Connor & Manchester, 2012). Suzanne Trim (NZNO Professional Services Manager) recognises that New Zealand could not cope without the support of OTNs and believes that NZ needs to be training more NZ-RN's to sustain its workforce for the future rather than rely on OTNs (O'Connor & Stoddart, 2013).

A quote from Buchan, Naccarella and Brooks (2011) highlights this point: "New Zealand is the developed country identified by Organisation for Economic Co-operation and Development (OECD) with the highest level of inflow and outflow of health professionals" (p. 154).

On the other hand, North (2010) has identified there are equal numbers of NZ-trained nurses working overseas as there are in NZ. While there are many 'push and pull' factors for NZ-trained nurses to seek employment elsewhere, the health reforms initially influenced nurses to leave NZ (Carryer et al., 2010).

The Recruitment of Overseas Trained Nurses to NZ

There are a number of ethical implications to consider when recruiting nurses from overseas, especially from poorer, less developed

countries (Walker, 2009). For many OTNs, becoming a nurse may be viewed as the way to gain entry for the entire family into a developed country. Many countries are thought to be training more nurses than there are employment opportunities within their own countries. The intention is to export these nurses, and has become reliant on the remission that is sent back to their families to augment their economy (Aitken et al., 2004; Walker, 2009). Dwyer (2007) states that although countries such as the Philippines have now included remittances as part of its development plan, the consequence of the Philippine's using nurses as a commodity to be exported, has resulted in a substantial nursing shortage. At the time of his report, there were around thirty thousand nursing vacancies in the Philippine's. However, as pointed out by Lin (2009) in her study, a large proportion of Filipino nurses have left the Philippines, to work elsewhere in the world resulting in a brain drain of future professional leaders in nursing in the Philippines and potentially damaging the quality of healthcare. The recent typhoon Haiyan, with its devastating consequence, also highlighted the severe shortage of health professionals available to assist.

The consequences for many of the poorer countries where their nurses are seeking employment overseas are detrimental and destabilising for their health systems. Workforce statistics available from the Nursing Council of New Zealand (NZNC) (2011) state that 17% of nurses are recruited from South-East Asia and 11% from India. The Philippines is by far the biggest supplier of overseas trained nurses worldwide (Kaelin, 2011). Consequently, over the last decade the emigration of health care workers throughout the Philippines has resulted in the closure of 200 hospitals, primarily in the rural areas (Kaelin, 2011). The significance of these closures have meant reduced access to healthcare for the less privileged communities (Kaelin, 2011). There has also been an increase in the patient: registered nurse ratio, where numbers can be seen ranging from 1:40 to 1:60 (Kaelin, 2011).

Consequently, this has reduced RN availability and increased non-registered workers and families caring for patients.

While there many 'pull' factors for health care workers to emigrate, such as higher wages and better living conditions, there are the ethical implications that must be considered by developed countries when planning their future work force structure.

The Impact on Patient Care

While NZ has become reliant on OTNs, one needs to consider the impact on patient care when filling vacancies with nurses for whom English is their second language and the level of support that is required to ensure these nurses are practising competently. The NZNC has recently implemented the need for all overseas-trained nurses, excluding Australian-trained nurses, to sit an English language examination prior to obtaining NZ nursing registration to ensure that OTNs can communicate effectively in the workplace (Callister, Badkar, & Didman, 2011). However, it is not just the spoken language that needs to be considered when recruiting nurses from overseas, as there are non-verbal cues from patients and families, as well as technical colloquialisms and idioms that have been reported as difficulties to overcome (Tregunno, Peters, Campbell, & Gordon, 2009). O'Connor and Manchester (2012) have identified that NZNC is proposing for registration of OTNs stating that the nursing council is proposing changes to the registration of OTNs when gaining registration in NZ. Under the proposed changes, NZNC suggest that nurses from non-English speaking countries will need to meet tougher English language requirements to gain nursing registration in NZ. The NZNC believe there is a need for nurses working in NZ to be able to think independently, advocate for their patients and challenge any practice that may be deemed detrimental to patient care. Some OTNs may be challenged by this competency (O'Connor & Manchester, 2012). The

recommendations of NZNC correspond well with the aims of this study: to understand the challenges OTNs face, and the level of support required during the orientation period for them to practice competently in NZ.

It is the identification of the level of support OTNs may initially require to orientate into a new area and be able to care for patients competently that needs to be examined in more detail. A descriptive survey conducted by Brunero, Smith and Bates (2008), in Australia, concluded that a support role exclusively for OTNs should be developed, to offer a more detailed orientation process. The focus of my research study will be on the experience of OTNs. The goal is to identify information that will be useful for nurse managers to ensure that OTNs receive the support and development that may be needed to practice competently and safely in the NZ context.

Cultural Differences

Culture is a dominant paradigm that refers to the learned and shared information of morals, beliefs, and life ways of a particular group that are normally passed on from generation to generation (Lin, 2009). Culture influences the way one thinks, behaves and communicates with others (Lin, 2009). Yi and Jezewski (2000) conducted a study of Korean-trained nurses adjusting to working in the United States. They highlighted cultural differences, problems-solving strategies and styles of inter-personal relationships as elements that are integral to practising competently. Adjustment into a new environment is an integral element when starting in a new work area. For OTNs cultural adjustment is an important part of the process. Lin (2009) describes cultural adjustment as adapting to a new culture and changing the way one behaves or thinks. It is an on-going process and part of the process for any new nurse to an area of work. An important part of nursing is problem-solving and mastering the skill of assertiveness, which is a proficiency that was identified within Yi and Jezewski's (2000) research.

My study explores the cultural differences, problem-solving strategies and communication styles within NZ and nurses who migrate here, to improve understanding of this issue. . Communication problems have been highlighted as a cause for adverse patient outcomes (Williams & Reid, 2009). Similarly, Walker (2009), in her paper on the ethics of nurse migration, emphasises that while there are benefits from filling vacancies with OTNs, they are often outweighed by language barriers and cultural differences. Unless this is well managed, the opportunity for personal and professional growth is limited. However, the processes that needs to be put in place in order for this to be 'well managed', are yet to be clearly identified.

A literature review by Woodbridge and Bland (2010) sought to identify significant factors that helped/hindered OTNs becoming competent and confident in the NZ health system. They identified some strategies such as on-going professional education, ensuring cultural safety and offering mentoring in practice environments. Woodbridge and Bland (2010) recommended that further research is required that is NZ in context.

Summary

Recruitment of nurses from overseas is not new to New Zealand, or in fact, any developed country. However, what has changed is the increasing percentage (21%) of OTNs within the total RN workforce within NZ. This position presents significant challenges for a CNM in an acute care setting whose principal role is to ensure safe, quality patient care by a competent and compassionate workforce.

Several studies have begun to identify the issues involved in recruiting OTNs highlighting: cultural differences, language barriers, differences in practice and differences in social norms as barriers for OTNs trained nurses transitioning to their new workplace. It is against this background that I will now progress the purpose and design of this practice project in the following chapter.

CHAPTER TWO: METHODOLOGY and METHODS

This practice project was undertaken as partial fulfilment for the completion of Masters of Health Practice. It was guided by an exploratory qualitative descriptive approach. Qualitative research is an inquiry in the natural setting, exploring human experience (Magilvy & Thomas, 2009). Qualitative exploratory descriptive research is useful when the researcher wants to explore an area of interest. In this case: *What are the difficulties experienced by overseas nurses in their transition to the NZ practice context?* by summarising and understanding the phenomena (Ranse, Yates, & Coyer, 2012). Qualitative studies allow researchers to explore human behaviour, perspectives, feelings, and experiences in depth, quality and complexity of a situation through a holistic framework (Polit & Beck, 2010). Qualitative Descriptive design is well-matched to a novice researcher, as it allows the beginning exploration of the human experience and summary of the phenomenon (Magilvy & Thomas, 2009).

This methodology also has appeal to novice researchers because qualitative descriptive studies are perhaps the least theoretical approach when compared to other qualitative methodologies (Sandelowski, 2000). Ranse et al. (2012) state that qualitative descriptive methodology is useful when one desires to understand further an area of interest and enable the ability to summarise the findings. Using a constructivism epistemology, I explored the experience of OTNs. Crotty (1998), explains that “constructivism epistemology holds that meaning, come into existence in and out of our engagement of our realities in our world. There is no meaning without a mind.” (p. 8). By utilising the lens of constructivism, one can discover the meaning of the experience of OTNs. that is how they develop meaning of their experience which can be utilised for future

nurses in order to create a positive and comprehensive transition into the NZ health sector.

The positioning of constructivism is in the qualitative paradigm. Developed during the 1960s, the introduction was chiefly as a result of wanting to increase the support and general approval of qualitative research (Giddings, 2006; Giddings & Grant, 2006) Polit and Beck (2010) refer to the qualitative paradigm that, while there is still a belief in multiple realities and a desire to understand them, one must still strive to be as unbiased as possible. Sitting within this paradigm, the researcher can strive to learn what is the truth of the studied phenomenon, and develop themes for future developments. Constructivism is a perspective that addresses how realities are made. Using this approach looks at the experience and examines how people construct it. By gaining multiple views of the phenomenon, the researcher can interpret and understanding what is happening.

This chapter describes the purpose and design of this practice project. An exploratory qualitative descriptive methodology forms the basis of this study. The study population, study sample and study size are outlined. The method of data collection is described and the data analysis is presented using Clark & Braun's (2006) thematic analysis. Finally, the ethical aspects and rigour of the study are addressed.

The purpose of the study:

As a Nurse Manager, who has the responsibility for the quality of patient care and the employment of suitably qualified RN's, I am very keen to better understand the assimilation experience of overseas trained nurses into the NZ health system with a view of better being able to meet their needs. The purpose of the study was

to explore the experiences of registered nurses (RNs) who have migrated to NZ within the last two years. It focused on the RN's perception of this experience and explored any difficulties they may have experienced when transitioning into the New Zealand health system.

Many countries are thought to be training more nurses than there are employment opportunities with the intention of exporting these RN's, relying on the remission that is sent back to their families to augment their economy (Aitken et al., 2004; Walker, 2009). The consequences for many of these poorer countries where their RN's are seeking employment overseas have been detrimental and destabilising for their health systems. The latest workforce statistics available from the Nursing Council of New Zealand (NZNC) (2011) state that 17% of nurses are recruited from South-East Asia and 11% from India.

While NZ has become reliant on overseas trained nurses (OTNs), consideration needs to be given to the impact on quality patient care when filling vacancies with OTNs, for whom English is a second or third or even fourth language, and the support that is required to ensure that these nurses are practising competently is significant.

Design:

An exploratory qualitative descriptive methodology guided this research study. Polit and Beck (2010) describe a research design as "the overall plan for addressing a research question" (p. 567). Qualitative research uses an emergent design, in that the researcher will make on-going decisions reflecting on what has been learnt in order to have the results reflect on the experience of the participants (Polit & Beck, 2010). Sandelowski (2000) states that the qualitative descriptive design remains close to the participants stories so that the inquiry produces a description that provides an insight which is "a complete and valued end-product in itself" (p. 335). Sandelowski

(2000) has advocated that a qualitative descriptive approach is advantageous if a simple description of the phenomenon is required she further advises that this approach has the possibility of providing answers to questions relating to practices and policies. Therefore, a qualitative descriptive design appears appropriate as this study is seeking descriptions of overseas trained nurse's experience when transitioning in the NZ health practice context.

The study population, sample and size:

The researcher presented to the Charge Nurse Managers (CNMs), a proposal for the research to be conducted over the course of 2013. She then asked for all CNMs to place posters (Appendix: B) within all the staff room areas on all the inpatient ward areas across 2 sites within our DHB. Included on the advertising posters were contact details of the researcher so that participants were able to contact and obtain further information about the research. Once contact was made, the researcher distributed information packs (Appendix: A) to the potential participants. Included within the information packs was the informed consent form (Appendix: C) and demographic form (Appendix E). Between four to six participants was the number stated in the ethics proposal as required for this study. Participants were overseas trained nurses employed in a General Surgical or General Medical ward in the DHB. They must have been employed between 6 months and 2 years, and for whom English was not their first language. The researcher had hoped to have a cross section of ethnicities to be involved in the research. However, the participants were all from the Philippines. A total of seven participants volunteered to be a part of this study. Of the seven volunteers three of the participants did not meet the inclusion criteria therefore were not included.

Following the recruitment of participants, the researcher then selected from the returned consent and demographic forms. A consent form and demographic form were included for the participants to complete; this enabled the researcher to review and select participants according to the inclusion criteria.

- Any participant who has not returned a consent form will be automatically excluded from selection.
- Any participant who does not meet the selection criteria as outlined will be excluded from selection.

It is important the participants' do not report through line management to the researcher because this could provide or provoke unbiased and socially desirable responses. Overseas trained nurses who have been employed for less than 6 months may still be too new to the NZ context and this would impact on the findings. For those overseas trained nurses who have been employed in the NZ context beyond the 2 year period may be in the process of becoming or have become acculturated to the NZ context which would impact on the findings. The following were the exclusion criteria

- Employees that directly report to the researcher to ensure participants do not have a socially desirable response and reduce bias and conflict of interest.
- Nurses that are not employed within a ward setting
- Nurses who have been employed for less than 6 months and more than 2 years.

Data Collection:

Interview Setting

Each interview was conducted at the participant's convenience in terms of preference for time and place. Participants were given a range of examples such as their own home, a private office within the hospital or a café away from the hospital. All participants chose to conduct their interviews in a private office within the hospital. This enabled them to attend either before or after their shift which assisted in not encroaching on their own time to any major degree.

Participants choose where they would like to sit during the interview. All participants read the information prior to signing the informed consent form. A tape recorder, to record the interview, was placed on a table between the researcher and the participant.

Data Collection

One in-depth semi-structured interview was conducted for each participant. Polit and Beck (2010) describe semi-structured interviews are when the researcher has a broad topic or questions that need to be addressed during the interview. Face to face interviews allows for non-verbal communication and exploration of any points that may occur during the interviews. The interview focused on the participants experience when they first started working as a RN in NZ.

The following open-ended questions guided the semi-structured interviews:

- Tell me about your first few weeks working in the hospital?
- Think about a time you had a difficulty during the first few months and what did you do about this?
- What are the differences between working as an RN in your home country and NZ?

- What do you think would have made your transition to practice in NZ easier?

These questions were purely a guide as the response of the participants directed any further discussion. The researcher asked any specific questions to allow for expansion of any vague points or clarification of any areas. Interviews lasted between 55-65 minutes.

Data Transcription

The data collected from the interviews were transcribed verbatim within one week of each interview. The researcher utilised the service of a qualified transcriber (Appendix D). Each transcribed interview was typed with each line numbered and large margins to allow for line by line coding. The researcher and supervisor were the only people with access to the data. Each interviewee was given a pseudonym to maintain confidentiality. Once the data was collected, it was analysed and interpreted. The objective was to put it together in an orderly manner and arrange it in categories and themes. Lincoln and Guba (1985) define data analysis as a process where the researcher makes sense of the data. This study used a thematic analysis to review all the data collected

Thematic Analysis

The process of analysing research within the qualitative realm can often be arduous and time consuming. All research that is conducted must be analysed and arranged in such way that can elicit meaning from the data. The researcher began analysing the data once all interviews had been conducted and transcribed. A thematic analysis method was used to interpret the data. Braun and Clarke (2006) state that thematic analysis is commonly used amongst qualitative research. A six phase method has been developed by the authors for data analysis, which I have used.

There are six phases to a thematic analysis are described below:

Phases of Thematic Analysis and Description of the process
1. Familiarising yourself with your data: Transcribing data, reading and rereading, noting down initial codes.
2. Generating initial codes: Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for Themes: Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes: Checking the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic map of the analysis.
5. Defining and naming themes: On-going analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the Report.

(Braun &Clarke,2006,p.87)

Phase One: Familiarising with the data

Immersion within the data means to read and re-read the data in an active way, searching for meanings and patterns. The researcher utilised a transcriber for the interviews therefore once the verbatim notes were returned, reading and checking against the tape recorder was conducted. Throughout this process the researcher noted down any initial ideas for coding.

Phase Two: Generating Initial Codes

This phase begins once familiarisation with the data and initial ideas have been generated. Each transcript was analysed individually and

key words and phrases that were used by the participants were highlighted. This was the beginning of the formation of the themes and sub themes. Throughout this phase the researcher looked for any repetitive patterns between the data set noting down codes in the margins of each data set.

Phase Three: Searching for Themes

A theme captures the significant elements about the data in relation to the research question, and indicates some level of repetition or sense within the data set (Bamford-Wade, Tucker, Lees, & Water, 2012). This phase enables the researcher to re-focus the data to develop themes from the different codes that emerged from phase two.

Initial themes emerged: models of care, mentoring/preceptorship, adjusting to the norms, communication, proving oneself, helping others, learning the policies and knowing who to trust.

Phase Four: Reviewing themes

This begins once initial themes have been devised and involves fine tuning of those themes. It became evident that some of the initial themes could be combined and renamed creating clear distinction between the themes while maintaining internal homogeneity within each theme.

Phase Five: Defining and naming themes

This is the point where themes are named and utilised for the final presentation of the data.

Themes	Data Extract
Becoming accustomed to the model of care	<i>So here was a big transition for me for me to actually get my patients' observations and to you know, do</i>

	<p><i>the showering and bed making because back where I used to work that was the Health Care Assistants job.</i></p> <p><i>We need to do all that stuff for the patients, given you're only given 5 patient load, 6 or 7 at most and in the Philippines, since your Health Care Assistants have that degree to actually help you with observations and the bed making and showering, you cater to about 60 patients procedure wise.</i></p> <p><i>A mixed one where there is only one Charge Nurse and one medicating nurse, so it's only me doing the orders, making the medication tickets, because we used medication tickets for that. Functional nursing, yes!</i></p> <p><i>It was tough because first and foremost the mortality of care from my country and this country is quite different and back home we don't usually do the bedside cares of a patient. We have the family doing that for us or a Health Care Assistant and you just document and like carry out doctors' orders and all those things</i></p> <p><i>Like text book wise I knew there was functional nursing, primary team nursing. I knew that there are different kinds of ways for work to be delegated, but back home we have functional nursing, so you're either a medicating nurse, a dressing nurse and so forth. So you just focus on one thing and yeah when I came here, like you do all the cares plus the gowning and the gloving was mind blowing for me. Like it was different reading it in the book.</i></p>
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	<p><i>The emphasis that its primary nursing here because it's very, very seldom in the Philippines that hospitals use primary, we always use functional because it saves man power.</i></p>
Mentoring/Adjusting to the norms	<p><i>You know for me, it's adjusting to whom to trust and whom to listen to was a big leap for me as well because I remembered when I preceptored as well, when I was a preceptee, my preceptor only showed me what to do within that day. She wasn't really keen to tell me that I needed to read more of the policies, which for her – she told me it was a waste of time. Yeah, and you know for a new person and it's a new hospital, a new setting and me coming from another kind of hospital, I made sure that I read the policies and I learned much more with the policies self-teaching myself rather than being a preceptee and running after her.</i></p> <p><i>If I had more time with a preceptor showing me how to do it and what to do. Then I think it would be easier for me and the other thing was that I thought would make a difference is like since I was alone, even if I wouldn't have a preceptor, like somebody to check with me.</i></p> <p><i>It's too short, 2 – 3 weeks of orientation is too short and yeah you feel as if you are paddling without a life jacket.</i></p> <p><i>I think for overseas nurses we always have these difficulties but in the orientation I think it should also be added to expect it to be tough.</i></p>

	<p><i>The down side of it was they also had a workload and she was juggling the time that she needs to care for patients and carry out her work load and preceptoring for me, so in the end I was learning more on my own, rather than being preceptored on the things that I should be doing according to the hospital</i></p> <p><i>I think the way that they tried to help us with the transition was quite good except for the fact that the study days came after. That was the only down side of it. So when I started having my own work load, some of the policies, even though it was given to us in a book, it was just written down so it was hard to imagine</i></p> <p><i>Yeah I think really adjusting to what the norms of my ward was a difficult part for me, aside from me knowing how the people, how they were eager to teach you as well.</i></p> <p><i>Yeah, I think my first few months there, you do the mornings usually on your first two months I think, I usually stay up until like 5 or 6 in the afternoon and read up on the policies. So that for me helped me a lot, knowing what the policies should be. Where the policies were located in our computer and that really helped me a lot and to find one nurse that was willing to help me adjust with that was the good thing with me.</i></p> <p><i>I feel so blessed even. So like I said I think it's really just a phase because you're new and expect everything to be easy, you just need to take in the changes because you're in a new country</i></p>
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	<p><i>and you should adapt.</i></p> <p><i>I thought the transition wasn't going to be that bad, but then what made it more difficult was the policies of the hospital, back home what normally guides us through the work is by the book.</i></p> <p><i>\</i></p> <p><i>It's that I work in a slower pace compared to the other nurses I was with, perhaps it was just my perception, but then I always felt with some of them, like they would look at me as if "You're too slow!" Yeah, I do understand the need to be efficient and things, but when you're like just being there for the first few days and going through the rounds and medicating, and the obs, and all of those things, it can be quite daunting and sometimes I would need to stop and think what do I need to do first and then I feel that maybe it's just me, but I felt as if they would look at me and be like "What the heck is she doing? Why is she so slow?" Just that feeling that you're not a par with all of them in terms of being so systematic and knowing</i></p>
Overcoming Communication Barriers	<p><i>For me to actually curb my accent, for him wasn't that much of a big deal, but it's also at the same time a bit frustrating, because why do you have to curb your accent for him and other patients can actually understand you, but then for him to give his consent for his care, you have to curb it. So I'd rather curb my accent for him, for him to give his trust and I can actually take care of him, rather than not doing that stuff and he wouldn't</i></p>

	<p><i>understand me and he would get frustrated at me.</i></p> <p><i>Yeah and the pronunciation I guess because I work with older people and they don't perceive high pitched voice very well. So at first they would say what? What? What? So I need to deepen my voice when I speak with them, because it really bothered me in the first few weeks because why can't they understand me? Why can't they get what I'm saying?</i></p> <p><i>I'm not afraid to ask what people mean when they say something that I don't understand, but what was strange for me was like "Sweet as," as what? It felt incomplete for me. Yeah but I was quite lucky that before I left I had a Kiwi friend who taught me.</i></p> <p><i>When I first came I would just stand there tongue tied because I feel so embarrassed and I would hide even so that I don't need to be face to face with them, but yeah it's quite unnerving. I'm trying to get over it</i></p>
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<p>Adapting to Inter- professional Relationships</p>	<p><i>Back home the doctors are gods. Like there are exceptions to the rule but what they write isIt should happen, but here when a patient is scoring you have the liberty to clinical assess and then do what you can and then when they come you just tell them I did this and they are quite happy about it. Back home you'd be thrown on your backside for doing those things. Back home I remember a patient was having chest pains and I did the ECG and all those things but when the doctor came he was quite irate with me because like I need to wait for him to do this and that, but here it's quite daunting but at the same time you feel good that you can work autonomously and act on what you think is best to do based on your assessments</i></p> <p><i>In the Philippines, doctors are treated really highly. Not that the doctors aren't treated really highly here, it's just that back where I live the doctors were like gods and you can't really talk to them unless they are your family members or they are your family friend. You know, that's how they see the nurse. They look at the nurses as purely home help. If it's in the home setting I mean. They look at nurses as like that. They never listen to what the nurses tell the doctors back home, like if you tell the doctors she's in pain, they might give some more pain relief, but they wouldn't ask you where the pain is, does the patient need a patch or the patient would be better off with like an Oxynorm for a short pain relief. They would</i></p>
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	<p><i>never ask that question and then they would tell you to do this and that and those are really not nurses procedures and they really push you to do that stuff and in the end</i></p>
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Phase Six: Producing the report

The final stage of the thematic analysis begins once all themes have been created. Write up of any qualitative descriptive research must include enough data extract to demonstrate prevalence of the theme. The final write up will follow in the next section of this report.

Ethical Considerations

Ethical approval was granted for this research by the AUT Ethics committee on 1st July 2013 (Appendix I). Any research that is undertaken that involves human or animals must attend to ethical considerations (Polit & Beck, 2010). The following three principles as cited by Polit & Beck (2010) i.e. beneficence, respect for human dignity and justice, will be followed to make sure that no harm or malice will come to the participants. Given the NZ context of this work, the role of the Treaty of Waitangi in ethically sound research will also be discussed.

Beneficence

As described by Polit & Beck (2010) beneficence is one of fundamental principles of ethics. Its meaning, *to maximise benefit, and minimise harm*, (Polit & Beck, 2010) must be paramount to the researcher. Strategies must be put in place that ensures minimisation to

all types of harm, emotional or physical. The purpose of this study is to develop concepts to improve the transition that OTNs may need to competently work in the NZ hospital system. Therefore, the intent is to benefit these nurses working in NZ. During the interviews participants may feel emotions or fears, consciously or not, therefore, information about an Employee Assistance Programme (EAP) is offered in the participant information sheet as well as information about the right to withdraw themselves and/or their data at any time. At no time during the research should a participant be disadvantaged (e.g. career progression), therefore the participant information sheet should be prepared with enough information about the research as well as contact details should the participant feel they need more information to make a choice to participate or not. Informed consent is essential to ensure that participants understand the nature of the research and the potential effects on them. This research did not include any participant that has not completed the written informed consent form. Should any of the participants raise issues of unsafe practice due to the confidentiality agreement the researcher kept this confidential, pointing out that what they have described is considered unsafe practice, encouraging the participant to seek assistance via the nurse educator and/or their charge nurse manager, in order to improve their practice. However, if the participant raises issues related to another nurse's unsafe practice then the researcher will encourage the participant to discuss this with their manager.

Respect for human dignity

The second principle as cited by Polit & Beck (2010) refers to the “right to self-determination and the right to full disclosure” (p. 122). Participants have the right to be included within the research without coercion. The researcher ensures participants have fully understood the aims of the research, and reiterates their right to withdraw from the research without any discrimination or repercussions. While there is a

level of expectation that OTNs will speak with a level of English in which they can communicate verbally, there is provision for an interpreter if the participant feels this is necessary. My personal experience has shown that occasionally OTNs have significant language barriers. A confidentiality agreement will be signed by the interpreter if this is required. The participant may bring up issues of discriminatory attitudes or behaviour and the researcher will be mindful of this and will encourage the participant to be specific about their experience. As stated above the participants will have information about EAP that is available.

Justice

The third principle refers to the right to privacy and fair treatment (Polit & Beck, 2010). The researcher will ensure that all information is kept in a secure locked cupboard, that demographic information will be kept separate to interview data. The transcription of interviews will be conducted by the researcher and kept on a secure password protected computer database. It is difficult to maintain anonymity of the participants due to CNM's being informed of the research and distributing the information sheets therefore pseudonyms will be utilised to protect the participant's identity.

Treaty of Waitangi

Honouring the principles of the Treaty of Waitangi is an obligation of all people living in NZ, when conducting ethically sound research.

Partnership: A cultural advisor was arranged for the researcher to consult with, to ensure that cultural considerations are explored and help is ensued with planning and any contact issues that may arise. An interpreter will be offered to the participants. The goals of the research are to enhance the transition for OTNs, in turn designed to benefit nurses in the future.

Participation: The principal role of the participants is to share their experience and stories of what it was like for them during the first few months of working at WDHB. Participants were asked to review the verbatim transcripts to ensure that what is reflected is what they stated.

Protection: All participants received an information sheet and a consent form, involvement within the study is entirely voluntary and all involved will be informed that they can withdraw at any time without repercussions. Privacy will be protected with pseudonyms. The interviews took place at a time and place where the privacy and confidentiality of the participant is protected.

Rigour

Polit & Beck (2010), cite Lincoln and Guba's notion of trustworthiness as a concept of rigour and suggests the four criteria for developing trustworthiness as: credibility, dependability, confirmability and transferability. More recently, according to Polit & Beck (2010), Lincoln & Guba (1985) have added authenticity to their criteria. Credibility relates to the trustworthiness of the findings and is the "overarching goal of qualitative research" (Polit & Beck, 2010, p. 492). Smythe and Giddings (2007), write that trustworthiness can be demonstrated through ensuring that the research is methodologically congruent and that when presenting one's research, the participants' stories resonate.

Dependability refers to the research being consistent and auditable, it is integral to ensuring that research is rigorous (Polit & Beck, 2010; Ryan, Coughlan, & Cronin, 2007).

Confirmability is concerned with truthfulness of the data presented and ensuring that the researcher has not misrepresented the findings but that they reflect a true representation of the participant's voice (Polit & Beck, 2010; Ryan et al., 2007; Tobin & Begley, 2004).

Transferability is also referred to as fittingness. It refers to generalizability of the research and whether the research findings can

be applied to other settings outside of the study (Polit & Beck, 2010; Ryan et al., 2007).

The fifth element added to this framework is authenticity. Tobin and Begley (2004) state that authenticity is unique to qualitative research and is demonstrated when the research can present a range of different realities. In order for me to demonstrate authenticity within my research I will need to ensure that the text is rich enough with descriptions that enable the reader to gain an accurate interpretation of the experience of the phenomena.

Summary

This exploratory qualitative descriptive study has sought to explore the difficulties experienced by overseas trained nurses in their transition to the NZ practice context. Using a constructivist epistemology, the researcher explored the experience of OTNs. By utilising this lens, the researcher was able to discover the meaning of OTNs' experience, which can be utilised for future nurses in order to create a positive and comprehensive transition into the NZ health sector. The participants joined the study because of the interest and desire to help other overseas trained nursing coming after them and because they met the stated inclusion criteria. Meanings emerged as the participants gave voice to their experience. The meanings became themes which were analysed using Braun & Clark's (2006) framework for analysis. This chapter has presented the methodology and methods for data collection. Ethical considerations underpin this study. The three core ethical principles of justice, respect for human dignity and beneficence were discussed, as were the principles of the Treaty of Waitangi: partnership, participation and protection. Rigour and trustworthiness were outlined.

Chapter three will present the main themes identified in the thematic analysis process and discuss their implications for practice.

CHAPTER THREE: FINDINGS and DISCUSSION

This chapter presents the findings of this practice project concerning the experiences of overseas trained nurses transitioning into the NZ health practice context. The identity of the participants is protected by the use of the pseudonyms and by removing any identifying details from the quotes used such as place of work. References to names of people in the quotations used have also been removed when presented in this chapter. Where quotes are used the pseudonym of the participant and page number of transcript is cited. Where words have been omitted ... is used to indicate this.

Four participants were interviewed all having worked in an acute setting between six months and two years. All had completed a competency assessment programme in NZ prior to them commencing employment as a RN in NZ. Mary, Jane, Karen and Jo all received their training in the Philippines and working at WDHB was their first role as a RN in NZ.

The process for data analysis has been discussed in the previous chapter with four identified themes emerging:

- Becoming accustomed to the model of care
- Being mentored/adjusting to the environment
- Overcoming communication barriers
- Adapting to interprofessional relationships

Becoming accustomed to the model of care

Nursing models or care delivery models are an integral part of the infrastructure for delivering patient care (Jost, Chacko, & Parkinson, 2010). Primary nursing or patient allocation, which focuses the nurses' attention upon persons rather than tasks, employs more nurses within the workforce and as such has more care hours provided by registered nurses rather than a non-regulated workforce (Dubois et al., 2013). Functional nursing represents a view of nursing, as a set of tasks, that can be carried out by a variety of care workers (Dubois et al., 2013). It is characterised by lower care hours provided by the registered nurse and appears to have a direct link to economic and labour constraints (Dubois et al., 2013). WDHB, at the time of the nurses entering employment, utilised patient allocation care delivery model. The wards

varied between 24 and 25 beds with 5-7 nurses (respectively) on a morning and afternoon and between 3-4 nurses on a night shift.

In talking about their experience of commencing employment as an RN in NZ, the RN's all described the difference between *"functional nursing"* and *"primary nursing"*. While this transition took place during the first few months this was clearly a shock for the RN's when first starting employment.

"So here was a big transition for me for me to actually get my patients' observations and to you know, do the showering and bed making because back where I used to work that was the Health Care Assistants job... we need to do all that stuff for the patients" (Karen p.1).

"It was tough because first and foremost the modality of care from my country and this country is quite different and back home we don't usually do the bedside cares of a patient. We have the family doing that for us or a Health Care Assistant and you just document and like carry out doctors' orders and all those things so apart from the shock of the big difference there's that pressure that you need to do 100% in this and that and the medication" (Mary, p. 1).

"So with that functional type of nursing everything gets carried out efficiently but over here you get to be all of the roles during a shift" (Jo p. 3).

"So the first thing was yeah, the shock of me doing the showering, bed making and stuff, but then as time went by, actually look back and see how did I even manage to take care of 60, now I'm taking care of 5" (Jane p.2).

"...Its primary nursing here because it's very, very seldom in the Philippines that hospitals use primary, we always use functional because it saves man power"(Jane p.4)

Jo's description when comparing the models of care was one of support towards the ways back home

"It's like there's not, I don't know, the time allocation that you do for each, I don't know, it gets swept up because it's like you have to be at their bedside at the same time you need to know what the doctors have written so everything gets cut off. You try to be in a hurry. You try to be in a rush with everything. So you won't be able to give out efficient care" (Jo p.3).

When Jane described the difference between the models of care she explained that while theoretically she was aware of the differences actually experiencing the difference was quite different.

“Like text book wise I knew there was functional nursing, primary team nursing. I knew that there are different kinds of ways for work to be delegated, but back home we have functional nursing, so you’re either a medication nurse, a dressing nurse and so forth....like theoretically I knew the difference but when you actually do it, it’s so overwhelming” (Jane p.3).

As a nurse manager, I had no idea that nurses from overseas had to face this stark difference in the way that they delivered care. It was quite an eye opener for me and one that I feel needs to be addressed within the very early transition days. Nursing staff that mentor new nurses need to be made aware of this difference, so that with this new understanding a greater depth of empathy, explanation and support can be given.

Being mentored/adjusting to the environment

Mentoring is a significant element of professional knowledge sharing in the work place (Allan, 2010). In regards to this study a mentor is a registered nurse who has been deemed experienced enough by their nurse manager to orientate a nurse to their area of work. Their role in this development is vital to the new learning. Mentoring is linked to role modelling practise, socialising the new nurse to the ‘norms’ of the environment and professional behaviours (Allan, 2010).

The current practice for the orientation period for new nurses with previous experience is to work supernumerary for 10 shifts alongside a mentor. However, it is common practice for CNM’s to allocate extended time for OTNs entering into the work force for the first time. This is not recognised within the funding model and is over and above the allocation of time allotted.

One distinct disadvantage to primary or patient allocation nursing model is the limited capacity for supervising new nurses to the work environment. Therefore, patients are being cared for by nurses with only limited knowledge and experience but very little supervision (Fernandez, Johnson, Tran, & Miranda, 2012). This can be seen represented within the nurses’ experience as their stories unfolded.

"If I had more time with a preceptor [mentor] showing me how to do it and what to do., then I think it would be easier for me and the other thing was that I thought would make a difference is like since I was alone, even if I wouldn't have a preceptor, like somebody to check with me" (Mary p. 10).

"Because probably we're short staffed, and they don't have time to sit with you, so you just have to look through" (Jane p.11).

"Yeah, there was a preceptor but I don't know, the down side of it was they also had a workload and she was juggling the time that she needs to care for patients and carry out her work load and preceptoring me, so in the end I was learning more on my own, rather than being preceptored" (Jo p.1).

"I think three weeks would have been sufficient if the preceptor had a minimum workload, like, her working like one of the other nurses with the same equal work load" (Jo p.2).

"It's too short, 2 – 3 weeks of orientation is too short and yeah you feel as if you are paddling without a life jacket" (Karen p. 4).

There is currently a three day study workshop for new nurses to attend. This workshop runs once a month, usually the first three days of each month. Most of the time nurses attend this study day after they have commenced employment. As pointed out by Jo, attending this workshop two weeks after she started made for a delay in her learning.

"Because I had my 3 days, 2 weeks after and it was I don't know. It did help me a little but it did not equip me with my first two weeks which made it difficult" (Jo p. 10).

Coupled with mentoring, is adjusting to the norms. One of the roles of a mentor is to assist new nurses' transition to the work environment. All four participants talked about learning all the new policies and guidelines. Often this was a struggle for their mentor to have the time to sit with them to go over policies. As Jo talks about this in her opening remarks, it is clear that this was upmost in her mind.

"I thought the transition wasn't going to be that bad, but then what made it more difficult was the polices of the hospital.....not everyone was willing to explain stuff" (Jo p.1).

A significant amount of self-learning took place during these first few months. Karen highlights what it is like learning all the policies.

“Yeah, and you know for a new person and it’s an new hospital, a new setting and me coming from another kind of hospital, I made sure that I read the policies and I learned much more with the policies self-teaching rather than being a preceptee and running after her” (Karen p.3).

Another element of adjusting to the environment for new nurses was highlighted by Jo and Karen, knowing whom to trust or just ask for help. For a new nurse coming into a completely different environment just having someone that they could go to for questions and knowing who this was, was a significant learning curve in the transition stage.

“Of course some of the nurses were willing to help me go through that as well and then they just told me, they are just trying to see if you will cope with the ward or not” (Karen p.5).

“I don’t know if they are just willing to teach us, willing for us to ask them a couple of questions no matter how silly it may be then I think it would have been easier, it would have been a better transition. It wouldn’t take us that long to adapt” (Jo p.11).

“They would just brush me off and say “read the policy”. So before I ask anybody what I’d like to hear, what I’d like to know and I know I could most probably find it in the policy, the I go through the policy first and then ask” (Jane p.10).

“I don’t want to be judgemental but I think they’re being a senior has gone to their heads....Face up tells you, okay, “I’m a senior you’re a junior. Go find it yourself” (Jo, p.9).

Of course there were some positive experiences as described by Karen

“Where the policies were located in our computer, and that really helped me a lot, and to find one nurse that was willing to help me adjust, with that was the good thing with me” (Karen p. 4).

“With asking different nurses and finally knowing who was willing to help me and take time to give me the answers that I was looking for, because sometimes they tell you “I’m too busy”, but some nurses, who

are even still busy will still lend you a hand, because at the end of the day it's you and your co-workers" (Karen p.4).

"You tend to know who is willing to help you, and who's not with asking questions" (Jane p.5).

Part of the mentoring process is to role model practise. Incorporating this is time management or expectations of the way things are done. Feeling overwhelmed in those first few months was highlighted by Mary and Jane.

"I always felt with some of them, like they would look at me as if "You're too slow!"....it can be quite daunting and sometimes I would need to stop and think what do I need to do first "(Mary p.2).

"I was struggling to finish my notes on time, but I overcame it but that feeling that you are left behind, that everybody goes home and you're still there, not finished with the notes" (Jane p.4).

"Yes like I said, my orientation for me was quite short. I think if I had more time with a senior preceptor like to model for me how to do it properly, like how to do it so you don't embarrass them.....if I had more time with a preceptor showing me how to do it and what to do. Then I think it would be easier for me" (Mary p.10).

Adjustment is all part of the process and becoming part of the team was highlighted as coping by Mary and Karen

"Yeah I think really adjusting to what the norms of my ward was a difficult part for me, aside from me knowing how the people, how they were eager to teach you as well....I think I thank my manager for that because she was open for me to ask questions... so I think coping with it and answering my questions helped" (Karen p.4).

"I feel so blessed even. So like I said I think it's really just a phase because you're new and expect everything to be easy, you just need to take in the changes because you're in a new country and you should adapt" (Mary p.7).

Overcoming Communication Barriers

Language barriers were a great obstacle for the four participants to overcome. During the interviews, while I had no trouble understanding all the participants, all four participants perceived communication difficulties during their transition.

Communication can be broken down into verbal and non-verbal.

All participants described their experience when communicating verbally with patients. In particular, the Older Adult who may suffer from hearing loss is vulnerable. All participants talked about ways that they attempted to be better understood with either trying to curb their accents or deepen their voice. At the heart of patient-centred care is effective communication. Patients and their families need to be fully informed about the benefits, harms and risks associated with various interventions. It is often the nurse who plays an important role in ensuring that a full understanding of what is happening in a health setting. Effective communication also helps build trust between the patients, their families and the health professionals. Effective communication has also been linked to reducing mishaps and errors (Hoffman, Bennett, & Mar, 2010). The experience of all four participants represents some of the difficulties in establishing therapeutic relationships and communicating with their patients and families.

“The most difficult thing was the accent, like I speak English really well, I learnt it in school, but it’s like I have a Filipino accent, there’s nothing I can do about that” (Jane p.11).

“Yeah they always tell me I have a very strong accent... it’s very difficult for them to understand, but I’m trying to bridge the gap and I’m trying to adopt the accent of a Kiwi accent, but I think I’m failing quite a lot” (Jo p.7).

“It’s totally the accent....I don’t see it as insulting, I see it as sometimes fun but you get frustrated especially with the patient I just told you about. He couldn’t understand me and he was my patient and I wanted him to get good care from me, but how can I obtain his consent if he couldn’t understand me?” (Karen p.14).

“It’s just quite frustrating but then I try my best to learn how the accent is with different patients” (Jane p.12).

“Yeah and the pronunciation I guess because I work with older people and they don’t perceive high pitched voice very well....so I need to deepen my voice” (Mary p.8).

Even though they perceived that the English language was not foreign due to their exposure to English in school, not being understood surprised them.

Verbal communication was not the only barrier to overcome, Mary describes that written work was also difficult.

“Not really verbal wise, it’s the writing, because the spellings are quite different, like we were taught to spell like the American way, so yeah” (Mary p.8).

Mary was able to overcome this difficulty with the use of technology.

“I changed my Microsoft word to British and that helped a lot...I discarded all my American books and started reading British ones” (Mary p.8).

Another example of some of the communication difficulties that the participants experienced during their first few months in NZ was the ability to understand their colleagues.

““But what was strange for me was like “Sweet as”, as what? It felt incomplete for me....I don’t know whether it’s a kiwi thing or it was just them, they were very, very enthusiastic. Awesome! At first I would feel insulated, like is he culturally I think, because we don’t show that much enthusiasm unless it’s a really big thing and you say “Alright, that’s great”. Is he mocking me? I don’t know if it’s genuine or not but then later on I found out it’s just how they are” (Mary p.9).

“I remember in my first few weeks we had an afternoon tea and someone said to “bring a plate”, I had no idea what that meant, so had to ask, I felt stupid afterwards but now I know” (Jane p.7).

Nurses often think that communication is secondary to their work of caring for patients. However, the success of an intervention is often reliant on nurses effectively providing the patient with appropriate information (Hoffman et al., 2010).

Adapting to Interprofessional Relationships

As stated, communication is vital to providing high quality care to patients. Whether this is communicating with patients' and families, or with colleagues it is one of the highlighted difficulties expressed by all participants. I have separated the two themes of communication and adapting inter-professional relationships, while there are some similar themes of communication and even adjusting to the norms of the work environment there were some integral elements of Inter-professional collaboration that became clear examples of some of the difficulties that the participants experienced. Nurses are required to work with many different health care professionals on a daily basis. While there is some debate around the meaning of interprofessional collaboration for the argument of this study I take it to mean that all health care professionals working together, breaking down the historical barriers for the common goal of creating the best outcome for the patient. All four participants expressed the differences in communicating with the medical staff. They conveyed that they had gained empowerment of their professional practice through this different communication process in NZ.

"Back home the doctors are Gods...but here when a patient is scoring you have the liberty to clinically assess and then do what you can and then when they come you just tell I did this and they are quite happy about it. Back home you'd be thrown on your backside for doing this things" (Mary p.5).

"back where I lived the doctors were like Gods, you can't really talk to them unless they are your family members or they are a family friend... they look at nurses as purely home help....they never listen to what the nurses tell the doctors back home" (Karen, p.7).

"I remember doing an ECG back home for a patient that was having chest pains but when the doctor became irate with me because I needed to wait for him to do this, but here while it can be quite daunting at the same time you feel good that you can work autonomously and act on what you think is best to do based on your assessments, So that's good" (Jane p.6).

The system of medical cover after hours, in NZ, as expressed by Jo is very frustrating for her to adapt to. She expresses the difficulties she experienced when trying to get in contact with medical staff after hours.

"I think the most difficult part over here. You don't know where your doctors are. You know there are doctors, but you don't know where they are....so their availability is the hardest part" (Jo p.6).

Speaking up as an advocate for their patients was initially a struggle especially in regards to medical staff.

"If I see something that I don't agree with, I don't because I still have that barrier, like "Oh my God, they might get mad" What I do is tell the coordinator. I think I need to work on that but yeah it's quite difficult" (Jane p.6).

"I'm getting the hang of telling them (doctors) what they've missed in the assessments or if I feel shy with doing it I will page it to them, just so I can still say I did my part, but yeah I need to get over myself. I need to get over that. It's quite difficult. It's unnerving really to say tell them off...but when I first came I would just stand there tongue tied because I felt so embarrassed and I would hide even so that I don't need to be face to face with them" (Mary p.10).

The Filipino nurses viewed nurses' relationships with doctors in NZ and in the Philippines differently. Doctors were viewed as having more power and control over patient treatment in the Philippines. Doctors in the Philippines did not value nurses' opinion regarding patients' treatment options. Nurses were supposed to simply carry out doctors' orders without questioning them. Mary speaks about how she felt more valued in NZ as a nurse.

"It was quite good... like other Filipino nurses' would know already that this is what is different in terms of the nurse doctor relationship. So they already told me that okay in here you can be more independent as long as it's backed up with clinical assessments" (Mary p.5).

Communicating between disciplines does not only involve medical staff, nurses are expected to clinically assess their patients and

refer to other members of the multidisciplinary team such as the physiotherapist, and occupational therapist.

Jane talks about her experience when she first came across this experience.

"I remember my charge nurse talking about discharge planning and what had I done to prepare my patient for going home. At first I didn't really understand but then I realised that I needed to speak about the PT (physiotherapist). At first it was quite difficult because back home even referring a patient to a physio was a doctors job, you're not meant to do anything like that unless the doctors says so being able to do this now I feel like more of a patient advocate, its good" (Jane p.10).

For Mary this was an exciting change in her role as a nurse.

"I was all smiles when they tell you that you can actually do that here. So you know, befriending the occupational therapist, physiotherapist, social worker, NASC (needs assessment service coordinator), it's a God send, especially where I work, a little bit of a change from a patient and you can actually refer him or her directly to the MDT (multidisciplinary team)" (Mary p.8).

Summary

This chapter represents the findings and discussions of this practice project. Four themes emerged from the analysis which were explained in greater depth utilising the participants' stories to describe their experience when transitioning in the NZ health practice context. The analysis revealed that this has been challenging for them but rewarding in terms of a greater sense of independence and advocacy for their patients.

The theme *"Becoming accustomed to the model of care"* has revealed the differences in the way care is delivered between the Philippines and NZ. Difficulties were expressed by all participants when first transitioning in the NZ health practice context. *"Mentoring/Adjusting to the environment"* was discussed in regards to the way that preceptorship occurs in this DHB, the lack of support that the participants felt during their orientation phase and learning to multitude of policies and guidelines that govern practice. The theme of *"Overcoming communication barriers"* highlighted examples of some of the difficulties that the participants had in being understood by their patients, and in turn, understanding some of the colloquialisms that

New Zealanders use. The theme of *“Adapting to Interprofessional relationships”* was discussed emphasising the differences between the doctor/nurse relationships, the need for increased advocacy and working collegially with all members of the health care team.

The next chapter will discuss limitations of the research, make recommendations for practice and further research, in the context of the scope of this small study.

CHAPTER FOUR: RECOMMENDATIONS

Recommendations for practice

While generalisations cannot be made in regards to all overseas trained nurses, the findings of this study do have some recommendations for practice.

It is clear that there are some significant differences in the model of care between the Philippines and NZ. I recommend that during the OTNs first few days that this difference, the expectations and model of care are made clear to all new nurses.

A customised orientation programme including training on communication skills, advanced medical equipment, cultural adjustment, nursing documentation and delegation may improve OTNs experience when transitioning in the NZ health practice context. I would recommend that the DHB has intakes similar to the new graduate programme. Rather than starting OTNs in an ad hoc way, that there are monthly intakes. I recommend that the first week is spent in the classroom learning the policies and gaining valuable insight and knowledge into the NZ context and models of care delivery with WDHB. The added benefits of creating this group are collegial support with other new nurses. While some CNMs may not agree with this concept and feel that this is delaying the start of nurses on their wards, I believe that the benefit for OTNs participating in this advanced learning early on in their employment will create a far more advantageous and significantly improved orientation period.

All nurses that are identified as a preceptor attend a cultural awareness programme to better enhance and develop their skills when communicating with OTNs.

Recommendations for Future Research

Future research studies are needed to expand the scope of this study. The themes represented in this study identify some clear difficulties that OTNs experience. However, given the small number of participants and the use of only one DHB, I would recommend that this

is extended to invite other DHB's to participate, which in turn will potentially increase the number of participants.

Limitations of the study

There are several limitations for this study. This study was carried out for a practice project as part of completing a Masters of Health Practice and therefore was subject to the time constraints of completing this within one year.

One potential problem with this study was finding a sufficient number of participants to volunteer to be interviewed. It was disappointing to the researcher that only Filipino nurses came forward. While their experiences invoked some rich data of some of the difficulties experienced while transitioning in the NZ health practice context, the researcher is unable to make generalisations that this would be the experience for all overseas trained nurses.

CONCLUSION

The purpose of this study was to describe any difficulties experienced by overseas trained nurses when transitioning in the NZ practice context. The aim was to explore the experience of OTNs adjusting to the NZ health practice context raising awareness for future nurses to enhance their transition. Using a Qualitative exploratory descriptive methodology and the epistemology of objectivism the researcher was able to view the data as an objective truth, limiting bias by sitting within the post-positivism paradigm. Utilising Braun and Clarke's (2006) thematic analysis four themes emerged from the data analysis: *becoming accustomed to the model of care, mentoring/adjusting to the environment, overcoming communication barriers, adapting to Inter-professional relationships.*

Knowledge about OTNs transitioning into the NZ health practice context is beneficial to the parties involved in the recruitment and retention of OTNs. The recommendations from this study will be shared with other CNM's in the DHB, so that collectively, we are able to better support the transition of OTNs to the NZ nursing practice context. Publishing in a NZ journal would also benefit other NZ employers.

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Participant Information Sheet

Date Information Sheet Produced:

22nd June 2013

Project Title

What difficulties are experienced by overseas trained nurses in their transition to the NZ practice context?

An Invitation

This is a letter of invitation to participate in a study to explore your experience when you first started working as a Registered Nurse in New Zealand. Before you decide you would like to take part it is important for you to understand why the research is being done and what it will involve. Please take the time to carefully read the Participant Information Sheet on the following pages and discuss it with others if you wish. Please ask me if there is anything that is not clear, or you would like more information.

If you would like to take part please complete and return the Consent Form and Demographic Form.

Please do not hesitate to contact me if you have any questions.

About the Researcher

During this research I am primarily a student, striving towards gaining a Masters in Health Practice. For me to gain this qualification I am required to complete some research. The area of interest for me is in the recruitment and retention of nursing staff. I have been a Nurse Manager for 7 years, over this time I have recruited many new nurses to the ward environment. For several of these nurses it is their first job in New Zealand. I have seen some nurses' struggle with the new environment and many who have left within the first year, stating lack of support as one component to making the decision to leave. I have a passion for nursing and all that this entails. To this end I am passionate about the nurses that I employ, and it concerns me that we do not fully support new nurses to our organisation. I look forward to completing this research to

gain insight into the experience of overseas trained nurses which I hope will inform not only myself but other Nurse Managers and Nurse Educators.

What is the purpose of this research?

The goal of this research is to gain a better understanding of some of the difficulties that are experienced by overseas trained nurses during their first role as a Registered Nurse in New Zealand. From the true lived experience of the participants stories it is the aim of the researcher to inform not only myself but other Nurse Managers and Nurse Educators of the themes that evolve and develop processes that will assist new nurses to New Zealand transitioning into the health setting. It is the hope of the researcher (myself) that this information will be published in nursing journals so that the information gained can be transferred and utilised by other Nurse Managers and Educators.

How was I identified and why am I being invited to participate in this research?

From the advertisement poster you indicated that you were interested in finding out more information about the research.

Excluded within this selection are any nurses that are direct reports to the researcher (myself)

What will happen in this research?

If you choose to be included you will be invited to come to an interview where your views, opinions and any information given will be treated with the utmost compassion and confidentiality. At this interview the researcher (myself), will conduct a 60-90 minute interview that will be audio-taped, transcribed verbatim (in your own words), for you to review and confirm that they reflect what you spoke about. No information will be used for any other purpose, you will be asked to give a pseudonym (fake name) to ensure that confidentiality is maintained. Typical questions in the interview will include: "Tell me about your first few weeks working in the hospital? Think about a time you had a difficulty during the first few months?"

You have also been asked to complete a demographic form, asking for information such as gender, ethnicity, and where you trained, this information will not be kept in the same place to ensure that data and demographics cannot be merged. The intention of this sheet is to ensure that there is a diversity of ethnicities and gender included within the study.

What are the discomforts and risks?

It is possible that while talking about your experience of moving to New Zealand and working in a new environment you may feel distressed or emotional.

How will these discomforts and risks be alleviated?

At the start of the interview you will be given information about free confidential counselling through the Employee Assistance Programme (EAP). You are welcome to access this service at any time and with full confidentiality. During the interview if you feel that you do not want to talk about something, full support will be given to your decision. Your involvement in the study is voluntary and you may withdraw your participation from the study at any time and/or withdraw any data that you have provided to that point, if you choose to withdraw from this research you will not be disadvantaged in any way. A cultural advisor will also be available if you need this support through the Asian

support team, an interpreter can be provided for the interview if you feel this is needed. This person will have signed a confidentiality agreement. You are welcome to bring a support person with you to the interview, this person will also be required to sign a confidentiality agreement.

What are the benefits?

It is the hope of the researcher (myself), is that this research will provide a foundation for future decisions on the development that overseas-trained nurses may need when transitioning into the health system in New Zealand. Confidentiality is assured, and the ward that you work will not be identified in any part of the research. As stated the research will be written up in the form of a practice project in a Master's degree.

How will my privacy be protected?

You will be asked to give a pseudonym (a fake name), this will be used to prevent any identification of any of the participants. Demographic and interview data will be stored separately.

What are the costs of participating in this research?

The only cost of this for you as a participant is your time of 60-90 minutes. It is proposed that interviews will take place in a private office on the lower ground floor of North Shore Hospital, therefore travel costs should not be incurred.

What opportunity do I have to consider this invitation?

I ask that after receiving this invitation that you consider your involvement within the next 2 weeks

How do I agree to participate in this research?

You will need to complete an informed consent form and demographic form that has been provided within this envelope. Please complete these forms if you wish to be involved and send it back to the researcher through the internal mail in the sealed envelope provided. If you meet the inclusion criteria I will then contact you to arrange a suitable time for the interview.

Will I receive feedback on the results of this research?

You will be invited to a presentation of the findings and/or, receive a summary of the results. If you wish to receive a summary of the results please indicate this on the consent form with the address that you wish this sent to. It is anticipated that results will be available about 12-18 months post interview.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Anita Bamford-Wade, anita.bamford-wade@aut.ac.nz

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Dr Rosemary Godbold, rosemary.godbold@aut.ac.nz, 921 9999 ext. 6902.

Whom do I contact for further information about this research?

Researcher Contact Details:

Deborah Hogan,
Charge Nurse Manager, Ward 5, North Shore Hospital
deborah.hogan@waitematadhb.govt.nz,
021 681 664.

Project Supervisor Contact Details:

Dr. Anita Bamford-Wade
anita.bamford-wade@aut.ac.nz
921 9391 021 921 776

**Approved by the Auckland University of Technology Ethics Committee on 1st July
2013, AUTEK Reference number 13/129.**

WHAT DIFFICULTIES ARE EXPERIENCED BY OVERSEAS TRAINED NURSES IN THEIR TRANSITION TO THE NZ PRACTICE

This is an invitation to participate in a research project being conducted by Debbie Hogan.

Who?

- Any Overseas Trained Registered Nurse
- Working at WDHB between 6 months and 2 years
- This is your first Registered Nurse position in New Zealand

What?

- The goal of this research is to gain a better understanding of some of the difficulties that are experienced by overseas trained nurses during their first role as a Registered Nurse in New Zealand.

When?

- This research will take place between July and December 2013

How?

- Participation will involve a 60-90 interview
- All information will be kept confidential
- Participation is voluntary and you may withdraw from the study at any time.
- All participants will be given a pseudonym (fake name) to maintain confidentiality

Thank you for your time and consideration in participating in this research. If you would like to participate please contact Debbie Hogan

Email: Deborah.hogan@waitematadhb.govt.nz

Tel: 4868920 ext. 2689

Mobile: 021681664

Consent Form

For use when interviews are involved.



Project title: What difficulties are experienced by overseas trained nurses in their transition to the NZ practice context?

Project Supervisor: **Dr. Anita Bamford-Wade**

Researcher: **Deborah Hogan**

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 13th January 2013.
 - ☐ I have had an opportunity to ask questions and to have them answered.
 - ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
 - ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
 - ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
 - ☐ I agree to take part in this research.
 - ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐
 - ☐ I wish to be invited to a presentation of the results (please tick one): Yes ☐ No ☐
 - ☐ I wish have an interpreter present at the interview (please tick one): Yes ☐ No ☐
- (If yes please indicate which language you require) _____

Participants signature: _____

Participants Name: _____

Participants Contact Details (if you wish for a summary of the findings sent to you):

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 1st July 2013 AUTEK Reference number 13/129

Note: The Participant should retain a copy of this form.

Confidentiality Agreement



Interpreter/Support Person/Transcriber (please circle)

Project title: What difficulties are experienced by overseas trained nurses in their transition to the NZ practice context?

Project Supervisor: **Dr. Anita Bamford-Ward**
Researcher: **Deborah Hogan**

- ☐ I understand that the interviews, meetings or material I will be asked to translate/support/transcribe (please circle) is confidential.
- ☐ I understand that the content of the interviews meetings or material can only be discussed with the researchers.
- ☐ I will not keep any copies of the translations nor allow third parties access to them.

Translators/Support Person/Transcriber signature:

.....

Translators/Support Person/Transcriber Name:

.....

Translator's/Support Person/Transcriber Contact Details (if appropriate):

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

Date:

Project Supervisor's Contact Details (if appropriate):

.....Dr. Anita Bamford-

Wade.....

..

..... anita.bamford-wade@aut.ac.nz, 921 9391 021 921 776

.....

.....

.....

Approved by the Auckland University of Technology Ethics Committee on 1st July 2013 AUTECH Reference number: 13/129

Note: The Translator/Transcriber should retain a copy of this form.



Demographic Form

Project title: What difficulties are experienced by overseas trained nurses in their transition to the NZ practice context?

Project Supervisor: **Dr. Anita Bamford-Wade**

Researcher: **Deborah Hogan**

Please note this form is only be used by the researcher, its intention is to ensure that a cross section of overseas-trained nurses has been selected.

Gender: (please circle)

Female

Male

No

Country of training

Have you worked anywhere other than the country you have trained in?

(Please circle)

Yes

No

Years of practice since graduating

Length of time practising as a Registered Nurse in New Zealand in a hospital setting.....

Employment setting.....

First language spoken.....

Participants Name.....

Participants Signature.....

This form will be kept separately from the transcripts created from interviews.

Note: The Participant should retain a copy of this form.

From: Kelly Feng (WDHB)
Sent: Thursday, 7 February 2013 09:09
To: Deborah Hogan (WDHB)
Subject: Support for research

Hi Deborah,

Thank you for the opportunity to be involved in your research. After meeting up with and discussing your proposal I am happy to fully support you with cultural support should this be required.

Kelly Feng | **Team Leader**

Asian Mental Health Cultural Support & Coordination Service

Ph.: 09 4868920 ext. 3042

Mob: 021 240 9584

Fax: 09 4868347

Email: kelly.feng@waitematadhb.govt.nz

Add: 3 Mary Poynton Crescent Takapuna, North Shore

Private Bag 93503, Takapuna North Shore 0740

Dear Deborah

Awhina Research & Knowledge Centre has now received the relevant approvals for your study:

Title: What difficulties are experienced by overseas trained nurses in their transition to the NZ practice context?

Registration #: RM 0980712422

Please continue to forward to us copies of all correspondence regarding on-going ethics approval for this study (if any). The Research & Knowledge Centre Staffnet site contains further information which may be of use to Waitemata DHB researchers; such as how to access statistical advice.

Good luck with your study.

Regards

Awhina Research & Knowledge Centre
(09) 4868920 ext. 2127
www.awhinahealthcampus.co.nz



Private Bag 92006
Auckland 1020, NZ
T: +64 9 921 9999
www.aut.ac.nz

6 May 2013

Debbie Hogan

17 Meridian Court
Oteha Valley
North Shore City
AUCKLAND 0632

Dear Debbie

ST 0940250 Debbie Hogan

Master of Health Practice – Practice Project topic and supervisor confirmation

Thank you for submitting your PG1 Research Proposal application. Your proposal has been reviewed and approved by the Faculty of Health and Environmental Sciences Postgraduate and Research Committee 19 April 2013 meeting. Details are:

Topic: What difficulties are experienced by overseas trained nurses in their transition to the NZ practice context?

Primary supervisor: Anita Bamford-Wade

Start date: 29 April 2013

Expected completion date: 10 January 2014

Enrolment: Standard Practice Project enrolment

You will see processes for progress within the thesis paper are laid out in the Postgraduate Handbook. If you do not have a copy of this booklet please contact the Executive Administrator on (09) 921 9999 extension 7020.

The AUT website for forms and handbooks is:

<http://www.aut.ac.nz/study-at-aut/current-students/postgraduate-support>

Please feel free to contact me with any questions or clarification you may require.

Yours sincerely

Associate Professor Erica Hinckson

Associate Dean (Postgraduate)

Postgraduate and Research Office

Faculty of Health and Environmental Sciences

Cc Primary supervisor Dr. Anita Bamford-Wade



AUTEC
SECRETARIAT

1 July 2013

Anita Bamford Wade
Faculty of Health and Environmental Sciences

Dear Anita

Re Ethics Application: **13/129 What difficulties are experienced by overseas trained nurses in their transition to the NZ practice context?**

Thank you for providing evidence as requested, which satisfies the points raised by the AUT University Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 1 July 2016.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 1 July 2016;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 1 July 2016 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: Deborah Hogan hogies@xtra.co.nz