

The influences on the practice of Overseas Registered Nurses  
working as Health Care Assistants in Aged Residential Care  
in New Zealand; analysed through the lens of Pierre Bourdieu

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## **Abstract**

New Zealand relies on migrant nurses to undertake roles in aged residential care, which appear unattractive to New Zealanders. These roles include registered nurses and health care assistants. Many health care assistants in New Zealand aged residential care are qualified nurses in their countries of origin. This research aims to understand what influences overseas registered nurses' practice when working as healthcare assistants to better support their transition to being registered nurses in New Zealand.

Eleven participants who were overseas registered nurses working as health care assistants in aged residential care in New Zealand, were purposively recruited for this study. Eight participants were from India, and three were from the Philippines. All participants had worked as health care assistants for over six months at the time of the interviews. The interviews were recorded and transcribed verbatim using a professional transcriber. Data analysis involved repeatedly listening to recordings and reading the transcripts. Using the thematic analysis framework by Braun and Clark (2006) and Braun et al. (2019), the transcripts were systematically analysed to code data and cluster these codes into themes.

Bourdieu's theory of practice supported the interpretation of overseas registered nurses' characteristics, dispositions, and attributes developed over time and how these influenced their practice as health care assistants. The knowledge and skills acquired through nurse education and experience also influenced their practice as health care assistants.

Three main themes in the data were: a struggle for power, personal and professional habitus, and a game worth playing. The research revealed a downward trajectory that disempowered the overseas registered nurses, to a position where they felt they did not belong. Some participants explained how fitting in was difficult as they tried to understand the health care assistant role and build relationships with staff and residents.

In conclusion, the findings show that overseas registered nurses are valuable in providing good quality care; they bring many skills and attributes not recognised and valued in aged

residential care. The research concurs with previous literature that more support should be available to help transition overseas registered nurses into the workforce in New Zealand. A suggestion is that overseas registered nurses have a pathway similar to the new graduate program in New Zealand. This pathway would provide orientation and integration into the workforce. For those overseas registered nurses who wish to migrate before being eligible to register as a nurse, a program of study or internship which leads to registration would reduce the downward trajectory and loss of cultural capital. An improvement for staff at all levels to have education regarding working with people from other cultures, is also recommended. In particular, it is the responsibility of education providers to ensure this is incorporated into undergraduate degree curricula. The research implies that government agencies such as Immigration New Zealand, the Nursing Council of New Zealand, the tertiary education, and the aged residential care sectors, collaborate to improve the transition experience for overseas registered nurses. This collaboration is particularly significant to ensure the appropriate use of nursing skills in the global nursing shortage and to enhance the upward development of care for older people in New Zealand.

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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.

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## Chapter One - Research Context

In New Zealand, there is an over-reliance on migrant workers in the aged residential care (ARC) sector particularly in the health care assistant (HCA) role (St Andrews Village and The Salvation Army's Social Policy and Parliamentary Unit, 2017). Many of these migrants are registered nurses (RNs) in their home countries, who come to New Zealand prior to meeting the Nursing Council of New Zealand (NCNZ) criteria, to register and practise as a nurse. Overseas Registered Nurses (ORNs) often enter New Zealand on a student visa, which allows them to work a limited number of hours per week (Immigration New Zealand, n.d.-c). In order to support themselves, many accept employment as an HCA in ARC. This role may allow them to improve English language skills and gain an insight into the New Zealand healthcare context, but it is below their skill level as an RN. During this time, there is a significant pause in their nursing career (Mowat & Haar, 2018). This study intends to investigate this state of affairs for the benefit of those involved. The researcher's interest in this topic is because, compared to many migrants, the researcher, as a migrant from the United Kingdom, had a much easier passage to working as an RN in New Zealand.

The growing number of people reaching old age needing institutionalised care is a challenge for health services globally. This challenge is compounded by changing demographics and family structures, leaving fewer people to care for those in need and the reliance for ARC (World Health Organisation (WHO), 2011). In March 2020, there were 34,646 residents in aged care facilities in New Zealand (McDougall 2020). This figure was approximately 33,500 in 2017, (St Andrews Village and The Salvation Army's Social Policy and Parliamentary Unit, 2017) which shows an increase of over 1000 residents in this three year period. Despite the New Zealand government's strategies to promote health and wellbeing (Tari Kaumātua the Office for Seniors, 2019), the growing number of older people who will require health and support services is expected to increase (Callister et al., 2014; Ibis World, 2021; New Zealand Aged Care Association, 2021). This is likely because as the population lives longer new challenges and more significant co-morbidities are encountered. In particular is the expectation that there will be approximately 78,000

people in New Zealand living with dementia by 2026 (Ministry of Health, 2013).

Consequently, the need for caregivers to work in ARC is expected to increase in line with care demands (The Ministry of Social Development, 2015).

While there is a push to grow a workforce which reflects the cultural demographics of New Zealand, there is presently an over-reliance on migrants to meet the sector demands (Ministry of Health, 2016b; National Nursing Organisations, 2014; New Zealand Aged Care Association, 2021). New Zealand's long-term skill shortage list, now includes Registered Nurses to work in aged care, meaning they can apply for a work to residence visa if they have a permanent or long-term job offer as an RN (New Zealand Immigration, 2021). In contrast, the opportunity to apply for a work to residence visa is not offered to an ORN working as an HCA in ARC.

This chapter sets the context for the research project. The first section provides context to the migration pathway for the ORN who chooses to work as an HCA. It is about the caregiver, the HCA role taken by the ORN and the journey of migration to become a registered nurse in New Zealand. The second section is about ARC in New Zealand, to give an understanding into the new healthcare field the ORN is working in as an HCA. The history of ARC in New Zealand society and the future of aged care in New Zealand, as the challenge to health services of the growing aging population in New Zealand is discussed.

An outline of the thesis is presented at the end of this chapter.

## **The ORN as HCA in context**

This section aims to give context to the pathway overseas registered nurses take when employed as healthcare assistants in aged residential care in New Zealand. Information is presented on the unregulated workforce in ARC and an overview of nurse migration, highlighting an over-reliance on a migrant workforce. Migration to New Zealand is discussed. An outline of the pathway for an ORN to become an RN in New Zealand is also provided because this is the ultimate goal for the ORN working as an HCA. It is important to note that not all ORNs take the same pathway as it is not a requirement to work as an HCA prior to registration as a nurse.

## **Unregulated Workforce in Aged Residential Care in New Zealand**

The workforce in ARC in New Zealand consists of 36,000 staff, of whom 72 percent are HCAs (McDougall 2020). A high proportion of care provided in the aged care sector in New Zealand is given by unregulated staff such as HCAs, rather than qualified nurses (Burrow et al., 2017; New Zealand Labour Party et al., 2010). In New Zealand, a qualified nurse is either a Registered Nurse (RN) or an Enrolled Nurse (EN). Both RN and EN are regulated health professionals under the Health Practitioners Competency Assurance (HPCA) Act (2003) which was implemented to protect the public from harm when they receive care from a professional practitioner (Ministry of Health, 2018). The high usage of an unregulated workforce in health care is not unique to New Zealand. Countries such as the United Kingdom, the United States of America, and Australia also use support workers due to shortages and costs of hiring qualified staff (Duffield et al., 2014).

In New Zealand, HCAs in ARC are included in the unregulated workforce, referred to as kaiāwhina<sup>1</sup>, who are not covered by the HPCA Act (Ministry of Health, 2016a). The RN is responsible for directing and delegating tasks to an HCA. At the same time, the RN is accountable for ensuring that the HCA has the knowledge and skills to complete the task. Therefore, the RN is responsible for protecting older people from harm when an HCA provides care. However, the HCA does have legal accountabilities and must work within the boundaries of their role (Nursing Council of New Zealand, 2012a). These lines of responsibility and accountability between the RN and HCA are similar in other western countries such as the United Kingdom (Royal College of Nursing, 2011).

It is important to appreciate the responsibilities and accountabilities of both RN and HCA, since the role of the HCA has changed over time, because it is not regulated and the employer determines the function through a job description. This has led to the scope of the HCA developing from non-nursing work such as cleaning and stock keeping, to direct patient care such as showering and toileting. In some cases, HCAs are completing more complex skills such as taking vital signs, monitoring blood glucose, performing

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<sup>1</sup> Kaiāwhina is the overarching name to describe the non-regulated workforce in health and disability services in New Zealand. It does not replace specific role titles such as HCA (Kaiāwhina Plan, n.d.)

venepuncture, and administering medications (Burrow et al., 2017; Duffield et al., 2014). Due to staffing shortages and an increase in RN workloads, HCAs in ARC are expected to work somewhat autonomously (Burrow et al., 2017). ORNs, who are likely to be able to work with minimal supervision, and perform many of these skills, may be attractive employees as HCAs. But, employment as an HCA could potentially place the ORN in a vulnerable position, if asked to complete nursing skills outside of their job description.

A profile of the unregulated caregiver (kaiāwhina) showed these workers to be mainly female (91%), and older than other New Zealand workforce groups, with 54 percent being between 45 and 65 years of age. The profile also showed that most kaiāwhina have qualifications, but they are paid close to the minimum wage (Ministry of Health, 2016a). Recognising the need to develop this workforce it was hoped that the Kaiāwhina Workforce Action plan (2015-2020) would provide a career pathway for the non-regulated workforce in New Zealand (Kaiāwhina Plan, n.d.). However, it is reported that approximately 40% of caregivers in ARC are migrants on a visa (McDougall 2020). Work is being undertaken in the sector to attract New Zealanders to the role, including working with schools and Work and Income New Zealand (WINZ), to find school leavers and others who might be interested (McDougall 2020). In 2017 salaries increased for HCAs working in ARC, making the role a more attractive option for young New Zealanders. Turnover of caregivers was down from 27% in 2017 to 23% in 2019, indicating that more people were remaining in the role (McDougall 2020). Department of Labour (2009) projections suggest that the number of kaiāwhina need to increase threefold from 17,900 in 2006 to 48,200 in 2036 to meet expected demands for paid care of older New Zealanders. Therefore, it may be unrealistic to assume that these roles can be filled in the future without employing migrants.

Callister et al. (2014) reported almost one-third (31%) of staff caring for the older population in New Zealand were migrants who were much younger than New Zealand-born caregivers. In particular, it seems this work appeals to the more youthful migrant because in the age group 25-34 years, there were twice as many carers born overseas compared with New Zealand born. It is acknowledged by McGregor (2012) that many migrants working as HCAs in ARC in New Zealand will be qualified nurses in their home

countries. A growing trend noted is that many ORNs work as HCAs while studying and improving English to meet NCNZ requirements for nurse registration (McGregor, 2012). This may account for the attraction of the younger migrant population to work in aged residential care. Given that a large proportion of the aged care workforce is reaching retirement age (National Nursing Organisations, 2014), and it appears that young New Zealanders are not attracted to this work, it is likely that young migrants will continue to be needed to meet the Department of Labour workforce projections for the foreseeable future.

### **Nurse Migration**

One of the earliest nurses to migrate was Mary Seacole. She funded her own travel from Jamaica to offer her services, during the Crimean War (Smith & Mackintosh, 2007). Before this she had already travelled to England, the Bahamas, Haiti, Cuba, New Grenada and Panama. Her autobiography outlines some of the challenges she faced on her travels including others questioning her upbringing, gender and race (Staring-Derks et al., 2015). Smith and Mackintosh (2007) draw attention to how Mary Seacole's story exemplifies how she was ostracised and devalued, based on her race and class. This demonstrates the roots of hierarchy in nursing, particularly in the British colonial past. New Zealand nursing followed the Nightingale principles, which fitted western society's ideas about women at the time. The philosophy emphasised expected regular positioning in the hierarchy and obedience over taking initiative, caring, and showing empathy. Working under these circumstances led one generation to inflict the same misery on the next (O'Connor, 2010). Discrimination continues to be a challenge and ORNs can be exploited and devalued by their host country (Schilgen et al., 2017; van den Broek & Groutsis, 2017).

After World War II nurse migration became popular, with nurses working in war-affected areas such as South East Asia, Korea, and China, and developing countries of Africa and the Pacific. Since then, nurse migration has become a concern worldwide as qualified nurses are leaving developing countries to find better opportunities in developed countries. This leaves the home country struggling to provide adequate services due to a shortage of staff (Nursing Council of New Zealand, 2013b). According to the World Health

Organisation (2010) fifty-seven countries, many in Africa and Asia, have a shortage of health professionals as many seek to improve their careers and lifestyles overseas. Some positives for the home country include the development of new skills that can be used if the migrant returns home and financial benefits if money is sent to support families in their home country. In response to this global concern, the WHO commissioned the Global Code of Practice for International Recruitment of Health Personnel to ensure ethical recruitment practices between countries, particularly between developed countries and developing countries (World Health Organisation, 2010). According to Hwenda (2010), Canada, Australia and New Zealand were opposed to implementing the code, fearing the rights of people to migrate would not be upheld as well as understandings of the word “ethical” being misconstrued. As it is, the code says that developed countries should not recruit from any of the 150 countries listed unless there is an arrangement between the governments of both countries. The Code is voluntary, therefore there is reliance on governments working for the good of the international community, not only for the good of their own country. Despite the code, in New Zealand, 27% of nurses gained their initial nursing qualification overseas, which is the highest in all Organisation for Economic Co-operation and Development (OECD) countries (New Zealand Nurses Organisation, 2018). This demonstrates how New Zealand relies on migrants to fill nursing shortages.

Nursing Council of New Zealand statistics show that 27% of nurses registered, completed their initial nursing qualification overseas and that this group was younger than the nursing workforce as a whole (Nursing Council of New Zealand, 2019). The ethnic group with the most youthful age profile was Filipino, of whom 77% were under forty years old (Nursing Council of New Zealand, 2019). This is particularly significant because 50% of the New Zealand nursing workforce is likely to retire by 2035, conveying concern for the demand for qualified nurses in the future (National Nursing Organisations, 2014).

Nurses who complete their nurse education in New Zealand are predominantly New Zealand European, with eight per cent identifying as Māori<sup>2</sup> (Nursing Council of New Zealand, 2019). The number of nurses who gained their original nursing qualification

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<sup>2</sup> Māori are the indigenous people of New Zealand (Te Aka Māori Dictionary, n.d.-a).

overseas, including 5,687 (11%) from the Philippines, and 4,136 (8%) from India is higher than the number of Māori nurses in New Zealand (Nursing Council of New Zealand, 2019). These statistics indicate a mismatch if the nursing workforce is to reflect the demographics of New Zealand, where Māori are 16.7% of the population (Statistics New Zealand, 2020). There is a shortage of New Zealand-born registered nurses working in aged care as it appears they are not attracted to it (Nana et al., 2013). Presently most people who live in ARC are European. It is unclear, but more Māori will likely require ARC in the future, given the growing number of older Māori and a reduction in family members to care for them, as young Māori continue to travel overseas for work (Holdaway, et al. 2021). The aim would be for the workforce in ARC to mirror demographics of the residents. However, presently there is a significant mismatch which is likely to pose issues related to the provision of good quality, culturally safe care (Ministry of Health, 2016b).

The Future Nursing Workforce Supply Projections 2010 – 2035 (Nana et al., 2013) acknowledged that 41% of the overseas nurses registered with the Nursing Council in 2012/2013 were practising in the aged care sector. Interestingly, Immigration New Zealand changed the entry criteria in 2014 so that ORNs seeking visas for roles in acute care, will have five years' experience to ensure that migrant nurses are not competing with New Zealand nurses for new graduate positions. Changes were not made at the same time to the Registered Nurse Aged Care category, which required two years' work experience (Nursing Review, 2014). However this has since changed to a requirement of three years' experience in an acute hospital setting and is on the long-term skills shortage list (Immigration New Zealand, 2021). ORNs employed in ARC as RNs will have less experience than those employed in acute care. However, they are expected to care for one of the most co-morbid, highly complex, vulnerable groups in our society, including an increasing demand for dementia and palliative care (Jenkins & Huntington, 2016).

### **Migration to New Zealand**

Many migrants aim to gain permanent residency in New Zealand. Permanent resident visas are based on points accumulated through a variety of criteria including age,

education, work experience, English language skill and occupation. Before being considered for permanent residency, registration with the Nursing Council of New Zealand is required (Immigration New Zealand, n.d.-b). ORNs have reported that gaining nurse registration in New Zealand is a particularly long and arduous process. It can cost thousands of dollars because of the requirement to meet the International English Language Tests (IELTs) and complete a competency assessment programme (CAP) (Ho & Chiang, 2014; Walker, 2009; Woodridge & Bland, 2010). Many migrant nurses are misled and often pay huge amounts of money to recruitment agencies prior to arrival in New Zealand (New Zealand Labour Party et al., 2010).

The immigration occupation skills list is a directory of essential skills required in New Zealand at any given time. The list changes according to shortages of New Zealand workers to fulfil these roles (Immigration New Zealand, 2021). The HCA role is no longer on the essential skills list, perhaps because the number of HCAs in the aged care workforce is maintained by ORNs on student visas taking up these positions. Consequently, a migration scheme, where education is paramount, as suggested by Badkar, Callister and Didham (2009) has never eventuated. ORNs can travel to New Zealand on a student visa, if they are enrolled in full time tertiary education. During this time, they can work up to 20 hours a week in term time and full-time during vacations. Interestingly, students enrolled in Masters (Level 8) education or above have no restrictions on the amount of hours they are allowed to work (Immigration New Zealand, 2015). Lovelock and Martin (2016) completed one of the first studies in New Zealand focused on migrant workers in ARC. Their participants thought working in aged care would lead to permanent residency. However, the occupation skills list changed and their jobs would no longer allow them to meet the criteria required; leaving this group of migrants distressed and working on temporary visas, perhaps for some never gaining residency (Lovelock & Martin, 2016). The immigration pathway appears to provide no certainty. The list often changes due to perceived skill requirements, and migrants who initially come to New Zealand on student visas, have no future job or visa security. ORNs are required to wait until they have gained NCNZ registration as a nurse and have worked

in a permanent position as an RN for two years before applying for a Resident Visa (Immigration New Zealand, n.d.-b).

A booklet titled "Are you employing migrants in aged care?" was written by Immigration New Zealand (2014), which aimed to support employers of migrants to better assist them with the transition into the new setting. However, Ngocha-Chaderopa (2014) found that some managers did not understand the needs of migrant workers and, at the time, had no strategies to support their transition. The author suggested that New Zealand Immigration, Ministry of Health, Aged Care Facility Managers, and tertiary education providers must ensure that the quality of care for the older population is not put at risk by employing migrant workers (Ngocha-Chaderopa, 2014). Jenkins and Huntington (2016) also found that ORNs have little support when transitioning to work in ARC in New Zealand. While that study has limitations in transferability due to its small sample size in a single workplace, it suggests a struggle for ORNs, which provides a catalyst for further research in this area in New Zealand.

### **Nurse registration in New Zealand for migrants**

ORNs must apply to the NCNZ for registration following a rigorous process which includes having qualifications and English language ability assessed and verified. At the time this study was completed, English Language testing was either using IELTS at level 7 or Occupational English Test (OET) with a score of 350. Both IELTS and OET required reading, writing, listening, and speaking to be assessed (Nursing Council of New Zealand, 2022b). Since October 2019, there are two steps for ORNs to undertake before receiving a decision from Nursing Council of New Zealand about their eligibility to undertake a CAP. In most cases two years' experience as a nurse in the last five years is required. The first step is verification and authentication of documents through CGFNS, International Inc. costing approximately 430 New Zealand dollars (NZD). The second step is application to NCNZ, who will assess qualifications and compare them against New Zealand nursing standards, a step that costs 485 NZD. Additional costs may include translation of original documents into English, English language testing, and an International criminal history check (Nursing Council of New Zealand, 2022b). Successful applicants will then be able to apply for a CAP

through a provider of their choice. Fees for a CAP are between 9,000 NZD and 12,000 NZD currently. A CAP consists of theory and practice, incorporating an understanding of cultural safety, Te Tiriti O Waitangi (The Treaty of Waitangi<sup>3</sup>), and New Zealand legislation and guidelines. Competency is assessed by an experienced Registered Nurse in a clinical practice area, where candidates gather evidence to meet the 20 competencies set by NCNZ (Nursing Council of New Zealand, 2007). The CAP is provided by health care organisations alone or in collaboration with a tertiary education provider.

Understanding the pathway to registration is relevant because it demonstrates the long and expensive process for an ORN to become registered in New Zealand as a nurse. There may be a significant time lapse in the nursing career for the ORN who comes to New Zealand prior to meeting the criteria for a CAP and subsequent registration. It is during this time that some ORNs choose to work in ARC as an HCA.

## **Aged Residential Care**

This section will inform the reader of the context of ARC in New Zealand, to provide insight into the new health care field in which the ORN as an HCA is working. The development of ARC facilities, the ageing population, and the requirement for aged care facilities in New Zealand are discussed.

### **The Development of Aged Residential Care Facilities in New Zealand**

Even though New Zealand has had many years of western influence following British colonisation and the signing of the Treaty of Waitangi in 1840, Māori society traditionally retains a positive view of ageing and affords respect to older people. Retirement is often a time for extra work, taking on a leadership role as kaumatua<sup>4</sup> (tribe leader) or caring for mokopuna<sup>5</sup> (grandchildren). This is a cultural difference to the western approach of retirement which can make older people feel like they are no longer useful (Dyall et al.,

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<sup>3</sup> Te Tiriti O Waitangi (Treaty of Waitangi) is a document signed by representatives of the British Sovereignty and the Māori chiefs in New Zealand in February 1840. Applying the principles of Te Tiriti O Waitangi to nursing practice is one of the 20 competencies required to register as a nurse in New Zealand (NCNZ, 2012).

<sup>4</sup> Kaumatua are older people in Māori society, who are recognised for their age, knowledge, leadership and wisdom (Higgins, & Meredith, 2011).

<sup>5</sup> Mokopuna is a grandchild or grandnephew or niece (Te Aka Māori Dictionary, n.d.-b).

2014). Government policies have been developed from a European and socioeconomic worldview and have historically negatively influenced the health of Māori people. However ARC facilities were developed to meet the needs of non-Māori, who have remained the main occupiers since inauguration (Thornton, 2010).

After signing of the Treaty of Waitangi in 1840, New Zealand was governed by the British crown. The introduction of the Old-age Pensions Act of 1898 was the first step toward social security in New Zealand and was the first of this kind in the British Empire. The Act was based on the principle that the government had some responsibility for older people who could not afford to care for themselves (Minister for Culture and Heritage, 2014). Aligned with the introduction of this Act was a growth in residential care homes. In the 1880s and 1890s it was older men that predominantly needed such services, possibly due to poverty and poor social support being unable to marry as a consequence of the numbers of men who travelled from Europe compared to women (Tennant, 1983). From 1890 onwards, older people's homes were purpose built, often in rural areas, to prevent the mostly male residents having access to the influences of alcohol, which was thought to be the disgrace of institutions in urban areas. Homes segregated by gender, had dormitory sleeping arrangements, inadequate sanitation and the residents were referred to as inmates (Tennant, 1983). Tennant (1983) concluded it was the attitude towards these old men's homes that left an unfortunate legacy remaining in aged care facilities. Similar events were occurring in Great Britain, where the 1834 Poor Law meant that those without employment and without anyone to care for them had to live in workhouses. Men and women were also separated and those that could, worked in the house to be able to stay (Peace, n.d.).

Following the 1918 influenza outbreak in New Zealand, the Health Bill of 1920 created the Board of Health; public hospitals were in demand and numbers increased significantly (Bloom, 2000). Care homes for older people became more attractive with some established specifically for returning soldiers as a reward for service. New Zealand's first Labour Prime Minister Michael Savage, aimed to legislate for access to a wide-ranging health care system for all, with the introduction of the Social Security Act of 1938. Following the introduction of this Act, delivery of health services remained a combination

of public and private enterprises mainly because General Practitioners insisted on the right to charge patients that could afford it (Morgan & Simmons, 2009). Voluntary organisations such as ambulance and child health services continued to support the now complex health system. In 1938, just prior to the second world war, the government was already aware that rationing and inequity were inevitable as the need for health services began to surpass the financial resources to pay for them (Bloom, 2000). The end of the second world war saw advancement in science and medicine and it became the expectation of New Zealanders to be able to access new treatments at no cost (Easton, 2002; Morgan & Simmons, 2009).

Over the next thirty to forty years New Zealand governments supported private operators and welfare organisations to care for older people, by providing funding to ease the burden on public hospitals (Boyd et al., 2008). In 1961 the Rest Home Subsidy Scheme was established in the Auckland Area Health Board region and was introduced in other areas of New Zealand from 1966. This scheme included an income and asset test as residents were expected to contribute to the cost of their care. This testing had always been normal service in these types of institutions, but the scheme aimed to make contributions more appropriate (Shipley, 1996). By mid 1970s New Zealand had one of the highest rates of ARC occupancy in the world (Swarbrick, n.d.). Care of older adults in institutions was still unregulated and this would not change until the health service reforms of the 1980s and 1990s. The Old People's Homes regulation in 1987 changed the definition of what could be known as an old people's home. The regulation set minimum standards for staffing but did not differentiate between the different types of staff, for example nurses, cooks and cleaners. Following this in 1988 a regulation was made to ensure the facility obtained a license which defined the level of care being provided by the home (Boyd et al., 2008).

During the 1990s rationalisation of hospital care meant long term rehabilitation moved to old people's (nursing) homes and a Residential Care Subsidy was introduced (Lazenby, 2007). Prior to 1993 there were five different ways of receiving assistance for long term residential care depending on the type of facility and where the facility was situated. The Residential Care Subsidy replaced all five schemes and aimed to treat all older people who required long term care in the same way (Shipley, 1996). This new act recognised that

income and asset testing was common globally. Some countries, such as the United Kingdom also required the spouse to contribute to the cost of care whereas in Japan, the full cost of care was paid by the resident with no government subsidy. By 1993 retirement villages had become an attractive choice for those who could afford to pay and as private businesses recognised the growing market they expanded facilities to include a continuum of care including: independent living, serviced apartments and government subsidised rest home and hospital care (Boyd et al., 2008). It was projected that the demand for retirement villages would continue particularly for those over 75 years of age (The Ministry of Social Development, 2015). This gave rise to large corporations making profit from providing services for older people (Ryman Healthcare, 2015).

At the beginning of the 21<sup>st</sup> century, the Labour government legislated for the New Zealand Public Health and Disability Act (2000) which established twenty District Health Boards (DHBs) with the objectives of promoting integration of services and improving the health of the people in their community (Ministry of Health, 2014). Funding responsibility for long-term (continuing care) was transferred from the Ministry of Health to the DHBs in October 2003 (Organisation for Economic Co-operation and Development (OECD), 2005). The contract known as the Age Related Residential Care services agreement between DHBs and providers is reviewed annually (Ministry of Health, n.d.). The Health and Disability Services (Safety) Act (2001) replaced a number of previous pieces of legislations including the Old People's Homes Regulation (1987). A requirement of this Act was for health care services including ARC facilities, to meet the new Health and Disability Service Standards (2001) which were updated in 2008 (Ministry of Health, 2016a).

New Zealand Europeans remain the majority of occupants of ARC facilities, with only 7.6% of residents over 65 years being Māori in 2018 (Hikaka & Kerse, 2021). European occupants are more than double the number of Māori occupants in the over 80 year age group (Holdaway et al., 2021). The study by Holdaway et al. (2021) had limitations, including being researched in only one region of New Zealand. But given the lower life expectancy of Māori, cultural differences and the historical rhetoric of aged care facilities, it might be expected that European residents dominate the statistics. However it is

anticipated that as the population ages, the numbers of Māori seeking this type of care will increase as will the requirement for dementia and palliative care (McDougall 2020).

### **The future of Aged Residential Care facilities in New Zealand**

It is predicted that there will be an increasing demand for ARC facilities in the future (McDougall 2020; New Zealand Aged Care Association, 2021). This heightened demand is due to the change in the population demographic, which is expected to include 25% over 65 years by 2030 (Spoonley, 2020). The majority of people over 65 years, presently live in independent private accommodation, however the proportion that do so, decreases with age (Statistics New Zealand, 2013). A decline in health status and increasing co-morbidities mean that 55% of aged care residents are requiring a high level of care (McDougall 2020). An expected decrease in family members who are able to support older people in their own home also contributes towards the expected increased demand for facilities (McDougall 2020). In March 2020 there were approximately 35,000 residents in aged care facilities in New Zealand and this is likely to grow by 12,000 to 16,000 by 2030. With this increase, a corresponding rise in care staff is required (New Zealand Aged Care Association, 2021). This demand for staff will undoubtedly include a continued reliance on migrant workers.

In summary, ARC in New Zealand developed because of British colonisation and initially, the requirement of men who had travelled from Europe finding no other support as they grew older. Europeans have a higher need for care facilities in old age, and cultural differences between Europeans and Māori people, has led to occupants of ARC facilities being mainly European. However, it is predicted that the demand for ARC may increase for older Māori in the future. Over time legislation has changed to include licensing requirements for ARC facilities and income and asset testing for occupants. Large corporate businesses have started to make profits from establishing retirement villages, rest homes and hospitals. As the age demographic profile in New Zealand changes, a dependency on the growing aged care sector will increase. Consequently, the need for care staff will increase and the reliance on migrants will continue.

## **The impetus for this study**

*I am a Registered Nurse, born and raised in the United Kingdom I completed my nurse training in Sheffield, England in 1983. Following graduation, I worked as a nurse in Sheffield and London before I travelled overseas to the United Arab Emirates for three years. In 2003 I immigrated to New Zealand with my family to work as a Registered Nurse in Rotorua Hospital. My nursing registration and experience was my ticket for overseas travel. Following different nursing roles across the Bay of Plenty region in New Zealand and completion of a master's degree, I joined an Institute of Technology as a Lecturer in Nursing and Health Studies. I was recruited to teach ORNs studying a one-year program to gain a Bachelor of Nursing qualification in New Zealand. The program did not lead to NCNZ registration and participants were required to meet NCNZ criteria, including English Language testing and completion of a CAP. Many of the students who completed the program were unable to meet the NCNZ criteria. As the Institute of Technology was unable to deliver the Bachelor of Nursing degree for Registered Nurses from 2013, new programs were developed to attract students from overseas. My role changed to Lecturer on the Graduate Diploma of Infection Prevention and Control, the Graduate Diploma in Health Studies and the Diploma in Health and Rehabilitation. These qualifications were predominantly aimed at the international market and attracted registered health professionals mainly from the Philippines and India. To support their studies, many students found work as an HCA in ARC. I began to wonder how that would feel and what it would be like. I had worked in the United Kingdom and the Middle East, with nurses from the Philippines and India and I knew many were highly skilled and I saw the role as a HCA as "down skilling". As I was an ORN who had an easy passage to becoming registered and working as an RN in New Zealand, I felt motivated to highlight the position of an ORN who is unable to become registered as a nurse in New Zealand and who finds themselves working as a HCA. This quote below by Wacquant (2008, p.275) reflects how I felt as I embarked on this study.*

Within this idea is Bourdieu's belief that intellectuals have a civic mission to "intervene in the public sphere on matters for which [they have] competency," and to use the cultural, social, and intellectual capital that accompanies the position of the intellectual to expose the inequalities inherent in society, and the methods by which they are perpetuated.

*Thus, it became my civic mission to study and expose the predicament that is faced by ORNs who migrate to New Zealand, prior to meeting NCNZ criteria to register as a nurse.*

## **Outline of thesis**

The first chapter of this thesis has focused on the ORN as an HCA and the workforce in ARC in New Zealand. Nurse migration and the reliance on the migrant workforce are discussed, as well as the pathway to nurse registration in New Zealand to provide context for this research. The development and the future of aged care facilities add understanding about the new health care field where the ORN is working as an HCA. Chapter two is a literature review and the identification of a gap in knowledge that led to the research question and the aim of the research. Chapter Three outlines how a critical approach and the chosen methodology Bourdieu's Theory of Practice (1977), is congruent with the research question. Bourdieu's theory of practice ((habitus) + (capital) + field = practice) } and the concepts of reproduction, reconversion, misrecognition, doxa and symbolic violence are explained. Chapter four outlines the research methods used, including ethical considerations and participant recruitment, selection, and demographics. Data collection and data analysis using Braun and Clarke (2006) and Braun, et al. (2019) thematic analysis framework with interpretation using Bourdieu's three step analysis (Bourdieu, 1984) is presented, concluding in the outline of themes. Chapters five, six and seven present the findings from the research and interpretation using a Bourdieu lens. Chapter eight is a discussion of the findings and how these are situated within existing literature. A discussion on implications for practice and the opportunity for change is included and finally, contributions to knowledge, strengths and limitations and recommendations for further research are presented.

## **Conclusion**

Chapter one has set the scene for this research study. It has highlighted the over-reliance on migrants working in ARC in New Zealand. In particular, attention was drawn to the predicament of ORNs working as HCAs. While this is not a mandatory pathway for the ORN, it comes about because the ORN is in New Zealand, often as a student, and unable to meet the NCNZ criteria for nurse registration. The growing numbers of people living in ARC and the lack of New Zealanders to care for residents provides an opportunity for the ORN to work as an HCA. Migration to a new country is fraught with difficulty, so it is important to understand factors that influence nurses to migrate overseas, particularly if it means they are prepared to work at a lower skill level in the destination country. The aim of the research is to benefit ORNs by investigating the situation where they are working as HCAs in ARC in New Zealand. To understand what influences their practice while in the HCA role, the research will identify opportunities for change to improve support in their transition to New Zealand.

## Chapter Two - Literature Review

This review will explore literature related to nurse migration, in particular focusing on the journey for qualified nurses who are unable to gain registration in a host country and consequently work as HCAs.

### Search methods

Search engines used were Scopus and CINAHL via EBSCO host platform. Search limits were inclusive of date limiters 2011 - present, full text, English. The keyword searches included: migrant workers; migrant workers AND New Zealand or Aotearoa<sup>6</sup>; international qualified nurse; international educated nurse; overseas registered nurse; nurse migration; nurse migration AND New Zealand or Aotearoa. The Scopus search provided 12,648 articles when only migrant worker was used as a search term. This was reduced to 160 articles when the subject area nursing/nurse was included. Twenty articles were chosen for review because their title and abstract indicated that they were related to migrant nurses travelling from Asian countries to westernised countries including the United States of America (USA), Canada, Europe and Australia and/or working in aged residential care. Studies completed in New Zealand were also chosen for review. Eight articles were either literature or document reviews, eight articles were qualitative research, three were quantitative research, and one was a mixed methods study.

The CINAHL search provided 774 articles using the key words migrant worker, adding nursing/nurse reduced this to 51. Key words foreign nurses rendered 1313 articles, adding New Zealand, Aotearoa or NZ reduced this to 186 articles. 136 of these articles were from the Kai Tiaki Nursing in New Zealand Journal and mainly commentary relating to exploitation of migrant nurses and changes to pathways for overseas registered nurses travelling to New Zealand. Of the 50 remaining articles, 11 were chosen for review as they were peer reviewed research. Searching foreign nurses and migrant nurses with aged

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<sup>6</sup> Aotearoa is the Māori name for New Zealand

care/nursing home or residential aged care rendered a further 66 articles of which seven were chosen for review.

Key words international qualified nurse and international educated nurse resulted in 9 articles for consideration, but no new articles were found from this search. Key words “nurse migration” provided access to 171 articles, adding aged care/ nursing home or aged residential care narrowed this to 4 articles; one was chosen for review. Adding the keywords down skill and healthcare assistant to all searches rendered no further articles.

A total of 29 articles were chosen for further review due to the title of the article appearing to be of interest: articles referring to globalisation and professional/ethical issues of nurse migration and those from the United Kingdom (UK), the USA and Canada, Australia and New Zealand, India, Philippines, and Nepal. Articles were also chosen if they specifically related to overseas nurses who worked in aged residential care in the host country.

A Google search using the key words internationally qualified nurse; migrant nurses; workforce in aged residential care led to documents that were accessed from the World Health Organization, New Zealand Ministry of Health, The New Zealand Department of Labour, Immigration New Zealand, New Zealand Nurse Organisation (NZNO) and Nursing Council of New Zealand (NCNZ) websites related to workforce, overseas nurses and aged residential care. The google search also led to news articles revealing current issues in the aged care workforce in New Zealand.

## **Review of the literature**

Four themes related to international nurse migration were identified from a review of the literature: influences on international nurse migration; acculturation and socialisation; job satisfaction, and down-skilling. These four themes will now be discussed.

### **Influences on international nurse migration**

Several studies suggest that influences on nurse migration can be categorised into push, and pull factors. The push factors can be poor working conditions, including low pay, out-

dated technology and lack of employment opportunities. There is also the pressure from families to travel overseas to earn money to send home (Dimaya et al., 2012; England & Henry, 2013; Marcus et al., 2014; Walton-Roberts et al., 2017). A study by Smith and Gillin (2021) used an extended case method to study the ORNs' experience within ARC in the UK. The case studied was the intersection between nurse migration and the ARC sector. Smith and Gillin (2021) identified that Filipino nurses chose to migrate due to the economic and social security offered by the host country, which they do not have at home. The nurses in this study chose the United Kingdom as a destination because of the ease of moving there. The move was helped by the political structures that supported their migration, which enabled them to develop professionally and socially (Smith & Gillin, 2021). The study had strengths in that it used an in-depth analysis method which considered the literature and theory within an ethnographic case (Buraway, 1998). However, the article did not reveal methods used in relation to collecting the data from the ORNs, which could lead to questions regarding reliability and validity (Guba & Lincoln, 1994).

While the most significant pull factor is the chance to make money, the ease of migration processes including access to visas and provisions for family members to travel has been significant (Dimaya et al., 2012; Ho & Chiang, 2014). Studies suggest that migration with the whole family is salient because families are otherwise pulled apart (Marcus et al., 2014). The study by Marcus, et al. (2014) was carried out in the Philippines, the source country of ORNs. On the contrary, the study by Smith and Gillin (2021), completed in a host country, identified that Filipino nurses who migrate, might be looking for opportunities to be more independent and move away from the collective ideologies of the Philippines. When considering the contradiction between staying with family or gaining independence, there may be a view that those Filipino ORNs interviewed following migration, may be more outspoken once they have migrated. However, the study by Marcus, et al. (2014) interviewed representatives of public and private health and education organisations in the Philippines rather than nurses. The authors acknowledged that their findings were only a source country perspective and were not the views of nurses. The methods are clearly outlined which provided the reader with faith in the

trustworthiness and reliability of the study (Guba & Lincoln, 1994). Similar to Smith and Gillin (2021), Ortiga (2021) found that some Filipino nurses desired to be independent. This desire may have led them to look for other options for migration, when unable to secure a nursing position overseas, such as studying at a tertiary institution. The article by Ortiga (2021) was a review of government reports and newspaper articles which showed how potential migrants are guided into other sectors when opportunities overseas are on the decline or unavailable. Some ORNs are unable to gain suitable employment in their home country and they will also seek other opportunities, including domestic work or studying in another country, enabling migration to occur. This emphasises a misuse of skills in a time of nursing shortages (Ortiga, 2021; Salami & Nelson, 2014).

Some countries, such as the Philippines and India, have recognised nurse migration as a marketable commodity, leading education providers to prepare extra nurses for migration (Castro-Palaganas et al., 2017; Dimaya et al., 2012; Lovelock & Martin, 2016; Ortiga, 2021; Walton-Roberts et al., 2017; Woodridge & Bland, 2010). There is a risk that migrational “pull” factors can become a motivator to complete nurse training rather than the traditional motivation of caring. In the case of the Philippines, the surplus of qualified nurses has meant some are not able to secure employment in their home country at times when opportunities overseas are reduced, such as during the 2008 global recession and the 2020 Covid 19 pandemic. The surplus has led to graduate nurses being employed as volunteers to gain experience, which may support their application to migrate (Marcus et al., 2014). The ease of migration processes is significant in influencing migration choices. Along with this is the process to become registered as a nurse in the host country. Challenges faced in becoming registered with a professional body in the host country, include time-consuming and expensive processes, language expectations and issues with the comparability of qualifications between countries. These challenges often result in their nursing careers being put on hold (Ho & Chiang, 2014; Mowat & Haar, 2018; van den Broek & Groutsis, 2017). Pathways that lead to permanent residency in the host country will be most desirable. Enrolment in post-graduate study in countries like the UK, Canada, Australia, and New Zealand has influenced migration for many ORNs because of the potential for permanent residency (Walton-Roberts, 2015). Concerns over residency

status were also found to be important for migrant care workers in New Zealand; not only for security but because families could be reunited and education accessed at less cost (Lovelock & Martin, 2016).

The push and pull factors influence migration, but many migrants will use agents to help them navigate the complex migration and professional registration processes (Walton-Roberts, 2021). The agents see an opportunity to grow business and profit: they work across nations and organisations, including immigration services, professional bodies and tertiary education providers for mutual benefit. Therefore, agents may not have the ORNs' best interests as a priority. The use of an intermediary may be costly and end in the reward of migration, but this is often not directly into the nursing profession (Walton-Roberts, 2021). Once in a host country, migrants try to adapt both personally and professionally. The next section discusses the literature on acculturation and socialisation.

### **Acculturation and Socialisation**

The complexity of migration and registration processes is compounded by the challenges of navigating new cultural and professional practices (Chun Tie et al., 2019; Ho & Chiang, 2014; Zanjani et al., 2018). Adapting to a new culture has been perceived in two ways by ORNs. The first is being familiar with everyday life and how to integrate into the life of a new family, including understanding colloquial language. Secondly, adapting to the nursing profession in the host country includes not being able to use skills they accumulated in nurse education and experience. Instead they completed basic tasks such as showering and toileting, which family members would do in their home country (Matiti & Taylor, 2005; Zanjani et al., 2018).

The narrative literature review by Zanjani et al. (2018) stressed that nurses who migrate, need to learn about the host country's culture, from a caring for a patient perspective and the culture of the organisation and of the nursing profession. This review which was to understand issues related to migrant nurses' adjustment experiences, considered 36 articles published between 2007 and 2016. The authors acknowledged the shortage of studies in Australia and therefore also took a more global view. A clear outline of databases and search terms used is provided, giving the reader some confidence about

how choices were made relating to inclusion and consequently the quality of the review (Guba & Lincoln, 1994).

The first few months of settling into the country by a migrant, are essential to establish and understand their new role, and they may feel particularly vulnerable at this time. Language abilities may be an issue with migrant workers. Still these people also bring an array of different cultures, attitudes, and beliefs into the workforce, which needs to be managed very carefully (Reinhard et al., 2009). Areas of a struggle for ORNs as they transition to their new country, include differences in expectations of practice, patients that are more knowledgeable and have more rights, advanced technology and the use of disposables, language and communication, and feelings of being an outsider (Tregunno et al., 2009). In this Canadian-based study, Tregunno et al. (2009) suggested that a transition after registration might be required to support integration into nursing culture, and understanding of expectations in their new country. Similar difficulties were found in the literature review by Zanjani et al. (2018). In this Australian-based review, migrants had trouble with different problem-solving systems and developing interpersonal relationships due to communication challenges. Findings from a New Zealand-based review acknowledged that there is minimal research on the transitioning of migrant nurses to New Zealand, but similarities to Canada and Australia are likely (Jenkins & Huntington, 2015). In this review two searches were undertaken, the first for peer reviewed literature from Google Scholar, CINAHL and MEDLINE between 2001 and 2014. The second search examined grey literature such as reports, policies and discussion documents from New Zealand organisations and international websites. Articles were considered for relevance and transferability to the New Zealand context. All methodological steps were described; providing the reader with assurance this review was methodologically sound (Guba & Lincoln, 1994). Jenkins and Huntingdon (2015), note that the literature in their review focused on negative experiences such as long processes for registration, not feeling valued in a host country and working below their skill level. A suggestion from the review is that the positive experiences of migrant nurses is documented, which may go some way to supporting others who transition to a host country (Jenkins & Huntingdon, 2015).

The pull of the potential to earn more money and to have more career opportunities, is often met with barriers and discrimination that prevent ORNs from fulfilling their dreams in the host country. The discrimination is described in a way that means the person from the host country did not necessarily do anything against the migrant. Instead, the migrant workers just felt they were treated differently (Jose, 2011). Japanese nurses adjusting to organisational culture in New Zealand noticed a difference in the hierarchical structure within the health system. They were not used to working in collaboration with other disciplines. This study found that Japanese nurses needed to learn to become assertive and communicate with other disciplines to succeed (Healee & Kumiko, 2016). Facing these challenges leads to building resilience, and migrant care workers often find themselves adjusting their plans to help integrate into the host country. Once settled, in some cases, migrant care workers feel it necessary to support new migrants to avoid the stress that they had experienced (Ho & Chiang, 2014). While this is positive, it would be more appropriate to have more formal support mechanisms for ORNs to transition to a new country.

To some extent, acculturation and socialisation rely on job satisfaction, which will be discussed in the next section.

### **Job Satisfaction**

Support to aid acculturation is likely to improve job satisfaction, an important marker for positive migration outcomes and worker retention (Adebayo et al., 2021). This study by Adebayo et al. (2021) was a cross sectional national survey investigating the impact of acculturation on migrants working in aged care in Australia. The findings of Adebayo et al. (2021) were similar to much of the international literature that reports migrant care workers are not happy in their work. Goel and Penman (2015) also completed a study in Australia and findings included some job satisfaction from positive resident feedback, flexible hours and being pleased to have a job. The approach by Goel and Penman (2015) was different to Adebayo et al. (2021) as it was a qualitative study that used a focus group interview with seven migrant workers from three different ARC facilities. Ethnicities of migrants were not revealed, nor did the article mention whether these migrants were

nurses in their home countries. Despite the difference in methodology there were some similar findings related to dis-satisfaction in their work.

However, much of the international literature reports that migrants care workers are not happy in their work. A study in Australia found that migrant workers felt demoralised, overlooked, and isolated when working in ARC (Goel & Penman, 2015). Racial discrimination was felt by foreign care workers in the UK and Ireland, as patients refused to be cared for by migrants. This discrimination immediately affected the relationship meaning the quality of care could be affected (Walsh & Shutes, 2013). A previous study completed in the UK showed that ORNs working as HCAs had knowledge and skills not recognised (Stuart, 2012). They also knew when care was not good quality, but they could not do anything about it. Stuart also pointed out that this group of migrants were vulnerable and maybe bullied by other staff. A more recent study from the UK showed that managers did not recognise the backgrounds of migrants. Instead, they found it a problem because the migrants did not adopt the preferred attitudes or skills easily, which led to a reduction in job satisfaction (Kadri et al., 2018). Furthermore, a literature review considering research from the UK, Canada, and the USA highlighted numerous research studies where migrants encountered discrimination. The review concluded that fair treatment was crucial for job satisfaction and retention, and essential for providing good care (Walani, 2015).

New Zealand is no different, as studies show a lack of job satisfaction for migrant caregivers. In a report about the aged care workforce in New Zealand, McGregor (2012) wrote that migrant workers are not satisfied with their work. However, because they rely on employers for their terms and conditions and references for visa applications, migrant workers may be reluctant to complain. A survey by Walker and Clendon (2012) completed in New Zealand, found many patients did not want to be cared for by “a foreign nurse”. Staff also displayed prejudice and do not show respect to Asian nurses, often assuming that non-New Zealand training is inferior and speaking to them in a way that makes them feel inadequate. Communication and language difficulties are mentioned from New Zealand-educated nurses understanding of the ORN as well as the ORNs understanding of New Zealanders due to the amount of jargon and colloquial language

used by New Zealand health professionals (Walker & Clendon, 2012). Congruent with the Australian study by Adebayo et al. (2021), research by Brunton et al. (2020) in New Zealand acknowledged a need for support for both host and migrant nurses from managers and organisations to improve integration and subsequent job satisfaction for migrants.

Job satisfaction may rely on using skills that an individual is educated for, yet many migrants find themselves in jobs below their skill level in a host country (Adhikari & Melia, 2015; Negin et al., 2016). The following section will discuss the literature related to the de-skilling of nurses.

### **De-skilling**

Much of the literature that discusses nurse migration, mentions brain drain and brain gain (Brezis, 2019; Johnson et al., 2014). Brain drain refers to the migration of highly skilled, educated individuals who seek improvements in their careers and lifestyles in another country. It refers to the loss of skills, most often from an underdeveloped country to a more developed country that benefit. This benefit is known as brain gain (Kadel & Bhandari, 2019). In relation to the ORN as an HCA in ARC, a positive of brain gain for the receiving country could be that the residents receive higher quality care, but for the ORN, there is a potential for loss of skills (Negin et al., 2016). This loss of skills has been labeled brain waste.

Adhikari and Melia (2015) discussed brain waste as they investigated the experience of Nepalese nurses working in the UK. The term “brain waste” was used to describe the de-skilling of these nurses as they moved from highly skilled roles in Nepal to working in ARC, carrying out basic care that their families would provide at home in Nepal. This de-skilling led to disappointment, lack of job satisfaction, and loss of confidence to work in more technical areas of health care. De-skilling could also mean returning to their home country to previous work would be challenging, and any objectives to gain new advanced skills that could be taken back to their home country are defeated (Adhikari & Melia, 2015). Brain waste is further described as a devaluation of human capital that is not always known about until after migration and most often when the migrant wishes to return

home (Brezis, 2019). The research by Brezis focused on preventing brain waste and resulted in a model to help migrants decide when to leave their home country either before or after receiving higher education. No research was found that determines how a host country can prevent brain waste. On the contrary, the studies appear to merely highlight the brain waste. There is a potential for brain waste occurring within ORNs who work as HCA in ARC in New Zealand. They are not working as an RN and are probably not using the knowledge, skills and experience they possess.

A recent pay equity settlement for care workers in New Zealand has led to overseas degree qualifications from the Philippines, India, South Africa, Australia and the United Kingdom as Level 3 on the New Zealand Qualifications Authority (NZQA) scale. This is one level below the required level to receive the new top rate for a HCA (Careerforce, 2017). This has led to discrepancy as the overseas degree qualification is assessed as Level 3 for pay equity purposes, but may later be considered by New Zealand Nursing Council as equivalent to a Level 7 qualification allowing access to a CAP. Consequently, this has been viewed as an “insult” to ORNs working as HCAs (Nursing Review, 2017). At the time of writing, a solution has not been found for this.

## **Gap in Knowledge**

There is an abundance of research related to migration and the migration of nurses. Despite the large quantity of literature, little appears to be changing globally to ease nurses' transition between countries. The influences on migration, as discussed, such as push and pull factors, draw ORNs into a pathway that could lead to down-skilling and brain waste. This is an immense concern in a global shortage of nurses. Some countries are educating surplus to their requirements specifically for out-migration, which is a significant push factor. However, there appears to be little collaboration between countries to ensure this education will meet the needs of a host country (Castro-Palaganas et al., 2017).

Consequently, qualifications are not easily transferable between countries, leading to nurses working in lower-level jobs. There is acknowledgement in the literature that ORNs undertake roles below their skill level (Matiti & Taylor, 2005; Zanjani, et al., 2018).

However, much literature about nurse migration reports negatively on the experience (Jenkins & Huntingdon, 2015). How ORNs use their knowledge, skills, and experience gained from being a nurse, as well as the influence of their culture and background in these lower-level jobs, is not apparent in the literature. The gap identified in the literature therefore is what the ORNs bring to a host country, particularly if working in a lower-level position such as an HCA. The significance of knowing what resources the ORN brings could help policymakers support their transition into a host country. It could also support changes to ensure knowledge, skills, and experience are utilised in a host country appropriately, avoiding brain waste.

## **Conclusion**

While registered nurses continue to seek opportunities to migrate, host countries have an obligation to ensure a secure pathway for nurses to grow their careers. Migration to a new country is well documented as complex and costly economically, personally, and professionally. At a time of shortages of nurses globally, not using the nursing knowledge, skills and experience available appears inefficient. Arguably the older population with physical and mental disabilities (one of the most vulnerable groups in our society) are being cared for by those who are undervalued, given low pay, and discriminated against because of background and race (Adhikari & Melia, 2015; Nursing Review, 2017; Smith & Mackintosh, 2007; Walker & Clendon, 2012).

This literature review has identified and discussed four themes: influences for nurse migration, acculturation and socialisation, job satisfaction, and de-skilling nurses, thereby identifying a gap in the literature. This gap is the portrayal of the knowledge, skills and experience ORNs bring to a host country, specifically when working in a lower-level job. The impact of the ORNs' culture and background on their practice, is also not reported widely. The literature shows minimal research into nurses' transition into New Zealand. Specifically, no studies have been completed relating to the ORNs that chose to work as HCAs in ARC in New Zealand. In response to the lack of research, this study aims to benefit ORNs who work as HCAs by understanding what influences their practice, to improve the support in their transition to being a registered nurse in New Zealand.

# **Chapter Three - Theoretical Perspective and Research Methodology**

Formulated from the gap in the literature, chapter three identifies the research question and the aims of the research. The chapter outlines the critical approach, utilizing the theory of practice by Pierre Bourdieu (1977). Bourdieu's theory of practice (Habitus) (Capital) + Field = Practice is summarised to demonstrate how this methodology is congruent with the research question. To show their significance to this study, concepts of reproduction, reconversion, misrecognition, doxa and symbolic violence are elucidated. Reflection as recommended by Bourdieu (1999b), is also explained and in keeping with this recommendation, a personal reflection related to the methodology is provided by the researcher.

## **Research Question**

What influences the practice of overseas registered nurses who work as health care assistants in aged residential care in New Zealand?

## **Research Aims**

The research aims to benefit ORNs by investigating the situation where they are working as HCAs in ARC in New Zealand. To understand what influences their practice while in the HCA role, it is hoped the research will identify opportunities for change, to improve support in their transition to New Zealand.

## **Theoretical Perspective**

This study uses components of critical theory underpinned by the work of Pierre Bourdieu. The study is congruent with this theoretical perspective because the vision of critical theory and Bourdieu, is that change is always possible (Bourdieu, 1977; Calhoun, 1995; Morrow & Brown, 1994).

## Critical Theory

Critical theory exposes societal inequalities, questions values and assumptions, and challenges usual social arrangements (Calhoun, 1995; Morrow & Brown, 1994). It has the ontological position of historical realism, which is the view that reality has been shaped by a range of value systems in history, including social, political, cultural, economic, ethnic, and gender values (Guba & Lincoln, 1994). Epistemology in the critical paradigm, is subjectivism which is based on the understanding that knowledge is socially constructed and generated from the mind (Bourdieu, 1977; Calhoun, 1995; Crotty, 2010). Critical theory is different from interpretive inquiry because the researcher listens to the stories of the participants' experiences and considers how their background and culture may affect the experience (Bourdieu, 1977; Crotty, 2010; Morrow & Brown, 1994). Critical theory focuses on domination and power relations and aims to change society rather than merely explain it (Morrow & Brown, 1994). A critical approach is relevant for this study because broader fields of power steer ORNs into a post-migration pathway that results in them working as HCAs, potentially a role below their skill level. The ORNs' background and experience will impact their experience as an HCA, which this research seeks to reveal.

Pierre Bourdieu (1930-2002) is a leading French sociologist, philosopher, and anthropologist. His dialectical approach does not dismiss objectivism, which dismisses meaning in society, and perhaps this is why Bourdieu prefers not to label his theories as critical (Harker, et al., 1990). Bourdieu's epistemological stance is what he called "general science for practice" which is neither pure objectivism, nor pure subjectivism; therefore, requires some separation from each (Swartz, 1997). This stance fits with constructivism's epistemology, which is a belief that reality is an understanding based on interaction with society (Guba & Lincoln, 1994; Morrow & Brown, 1994). The connection between Bourdieu and critical theory exists because both seek to promote change and strive for less discrimination and a more democratic society.

Bourdieu was influenced by many theorists, most notably Karl Marx (1818-1883), Ludwig Wittgenstein (1889-1951), and Blaise Pascal (1623-1662). Bourdieu was able to consider the work of these theorists and position them more subjectively, seen as a "politicising of

theory” (Webb et al., 2002). For instance, the work of Marx concentrated on economics and analysis of class structure in society. Bourdieu criticised Marx’s objective world view, as it did not consider the wide range of practices that related to class, such as tastes in food, dress, housing, and a person’s characteristics (Bourdieu, 1977; Wilkes, 1990). Swartz (1997) clarifies that Bourdieu saw such representations as a way to heighten and exhibit social class. Thus, Bourdieu viewed the competition for recognition and power among people in a social group to be a fundamental dimension of social life. Bourdieu believed that revealing what creates power relations will make them less acceptable and may affect inequalities in the social world. Therefore Bourdieu’s work is positioned to reveal the hidden, and make visible the invisible, unacknowledged interests of the oppressed, which is one underpinning of critical theory (Swartz, 1997).

Bourdieu was also influenced by structuralism and phenomenology but moved away from these to develop a “Theory of Practice” that considers both objective and subjective worldviews (Bourdieu, 1977). Bourdieu suggested that a researcher observing a social situation has no place in the experience and therefore could view the experience objectively or through a phenomenological analysis. Both perspectives are unconcerned with the social dispositions of the observed, and the social conditions in which those being observed are working or living, particularly the dominant and hierarchical structures that influence the experience (Bourdieu, 1977; Swartz, 1997). Bourdieu believed the experience, therefore is dependent on the objective (structures and institutions) as well as the subjective (the person’s background and experience) (Bourdieu, 1977).

Bourdieuian theory is chosen for this study because Bourdieu’s interpretations of social order explain the paradoxes when individuals move into different contexts. This includes utilizing capital to enhance position within the social context and the interactions between individuals that display dominance and power differentials (Bourdieu, 1977, 1984, 1986b, 1998). Bourdieu's theory of practice fits this research because it is essential to consider the objective structures that influence practice and those characteristic practices that are part of the ORN's culture and background to gain a complete picture of what influences their practice in the HCA role in New Zealand.

## Methodology

### The Theory of Practice

Bourdieu used the terms habitus, field, and capital to explain interactions in the social world, explicitly relating to the interplay between structure, power, and agency (Bourdieu, 1977). Bourdieu described the field as anywhere social interactions occur between people, not necessarily a geographical location but a social space. Field and habitus are closely linked as each person's habitus is developed and transformed within the field. Capital refers to resources an individual brings to the field and is used to gain power (Bourdieu, 1977). Capital and how it evokes power are explored later in this section. Bourdieu's theory of practice as a research framework allows the researcher to examine individual and group actions developed from their background and the objective structures in a chosen field. To illustrate the relevance to this study, the Theory of Practice (Figure 1) and its components of habitus, capital and field are explained. Firstly, the concept of practice from a Bourdieusian perspective is defined.

Figure 1 Theory of Practice (Bourdieu, 1977)

$$\text{⌘ (Habitus) (Capital) + Field = Practice ⌘}$$

### Practice

Practice is everyday actions taken by people based on rules in society. The rules are written or unwritten and by living in the culture of a community, a person becomes familiar with the usual ways of doing things. However, background, culture, and experiences in everyday life influence a person's actions (Bourdieu, 1977, 1990). Bourdieu's theory of practice provides a framework to enable the researcher to understand the influences on everyday actions that are practice. Practice in the context of this research is the day-to-day actions of the ORNs working as HCAs in ARC. The ORN is an actor with a cultural background and a history of working as an RN, working in the role of HCA, responsible for providing care by responding to residents' needs, which is everyday practice.

## **Habitus and Field**

Bourdieu's work, developed when studying the social class structure, acknowledged that habitus depends on objective structures of the environment where individuals are born and grow (Bourdieu, 1977). Bourdieu (1977, p.78) defined habitus as "the durably installed generative principle of regulated improvisations, produces practices which tend to reproduce the regularities immanent in the objective conditions of the production of their generative principle ...". In other words, habitus includes the ingrained principles, attitudes, and dispositions developed throughout life, depending on upbringing and experiences that give the individual the ability to be socially adept in their surroundings (the field). Bourdieu clarifies habitus by using the analogy of the knowledge and understanding required when participating in a team sport, describing it as being able to "play the game" (Bourdieu, 1998). Bourdieu (1998, p. 80), writes "having a feel for the game is having the game under the skin; it is to master in a practical way the future of the game; it is to have a sense of the history of the game." This description depicts the influence of an individual's background and the ability to predict the future as part of habitus. To play the game is to be part of the team, and individuals in the team may have different understandings of the rules (habitus), which may depend on the difference in their background. However, team or group members develop a group habitus over time (Bourdieu, 1985; Shusterman, 1999). Shusterman (1999) adds that those familiar with the field will know the habitus (or follow the rules) without thought, as habitus is deep-rooted, not inborn but culturally developed. An anthropologist would study a society (or field) to work out these unhidden rules (or habitus). Bourdieu describes habitus using the term strategy rather than rule, as he depicts habitus as a series of unplanned but strategic moves that are developed in the individual's past but also rely on a prediction of future moves (Bourdieu, 1977). The habitus suggests knowledge and understanding of the rules within a field, which are not easily transferred to another field (May & Powell, 2008). However, it is recognised that habitus can be transformed when an individual moves from one field to another (Lynam & Cowley, 2007). This modification in habitus may be crucial if the original habitus is not bringing success in the new field (Moller, 2013). Costa and Murphy (2015) interpret this as a primary and secondary habitus, the latter being

developed as the person experiences new social situations. Habitus can be easily recognised in a new situation as it stands out from the norm, or an individual may consciously hide it, so they do not stand out (Costa & Murphy, 2015). Essentially participation in a field is required to form or change the habitus. Generally, people relate to others with a similar habitus more easily, and habitus can provide capital, or it can be a burden (Moller, 2013). Lynam and Cowley (2007) provide an example of this when studying migrants, stating that a lack of English language leads to difficulties when settling in an English-speaking country; however, speaking a second language (which is formed as part of habitus) can be an asset or capital in the new country. In most fields, there is competition between the players for power, and an accumulation of capital can lead to different types of power, which can be positive or negative. Different types of capital will be important in different fields; the consequence being that power is evoked.

Research can examine the development of a new habitus. Bourdieu developed habitus and field as a way of thinking beyond the objectivism/subjectivism debate, whilst recognising that both influence how the social world is constructed (Swartz, 1997; Webb et al., 2002). Bourdieu's way of thinking suits this study as ORNs move from working as RNs in another country to working as HCAs in ARC in New Zealand. Bourdieu (1999a, p.128) suggested that "individuals who move into a new space must fulfill the conditions that space tacitly requires of its occupants." Therefore, this research will consider primary habitus in terms of how it influences practice in the new field, how the ORN adapts to the new field, and how capital is accumulated or unused.

## **Capital**

Bourdieu's theory of practice has relevance to this study as ORNs bring an array of capital into the workforce, such as nursing knowledge and clinical skills. Capital may be used to enhance position and gain power, or it may be redundant. Conversely, capital may have a negative effect on the ORNs position in the field.

Bourdieu was influenced by Marx who saw capital as being related to economic factors that give a person status (class) in society. Bourdieu rejected Marx's idea that capital was purely economically suggesting that symbols, such as the way a person dresses, signify

power (Bourdieu, 1977, 1986b). Bourdieu viewed capital as all resources whether they are material or non-material that are desired in a particular social field to gain power. He further described capital as economic, cultural, social and symbolic (Bourdieu, 1986c). These different types of capital evoke different power dynamics which in turn may create struggles and influence position in the field (Swartz, 1997).

Economic capital is the accumulation of money and investments. Whilst Bourdieu did not see capital as solely economical, he did recognise the power money brings in terms of class structure in society (Bourdieu, 1977, 1986b; Rhynas, 2005). Cultural capital can refer to non-economic factors which influence achievement and is the main reason for positions of status in a field (Bourdieu, 1977). In other words, the possession of cultural capital gives rise to symbolic and cultural power.

Cultural capital is described as embodied, objectified or institutionalised capital (Bourdieu, 1986b). Embodied cultural capital includes competencies or skills that belong to the person who possesses them; with accumulation beginning in childhood (Swartz, 1997). Bourdieu (1986b) inferred that embodied cultural capital requires time and effort to be invested by the individual, which consequently enables self-improvement. Embodied cultural capital can be somewhat like habitus, but if something of habitus improves power or increases resources then it is part of capital (Crossley, 2005). For instance, as previously discussed regarding speaking a second language (which is part of a person's habitus) this attribute can become capital when used in a field where the language is not spoken by all; this is embodied cultural capital.

Objectified capital refers to owning objects of significance that can lead to symbolic and cultural power in a particular field (Parutis, 2014). Swartz (1997, p.76) refers to these objects as items that "require specialised cultural abilities to use" hence they give their user cultural power in a particular field. Bourdieu (1986b) observed that objectified capital stems from economic capital (having the money to buy things) but embodied capital provides power because the object owner will have the skill to use it. For instance, a person who wears a stethoscope (objectified capital) having the economic capital to buy it, displays a demeanor of importance and symbolic power. However, if the person has the

skill to use the stethoscope, they will possess embodied cultural capital and consequently may gain some symbolic and cultural power. In the case of an ORN working as an HCA in ARC in New Zealand, objectified and embodied cultural capital may not provide any form of power because they are not employed in the position to use it.

Institutionalised capital is ownership of academic qualifications and credentials that gives a person symbolic and cultural power in a particular field (Crossley, 2005). Attainment of academic qualifications can provide power to develop economic capital although Bourdieu's studies revealed that the education system does not advantage all people equally and therefore schools are a catalyst for inequalities in society (Webb et al., 2002). How well a person attains in school depends largely on the cultural and social capital the individual has been exposed to previously (Bourdieu, 1986b). Institutionalised capital may give symbolic and cultural power to the owner in a field, but this is not necessarily transferable to another field. An example of this is the ORN whose academic qualifications are not directly transferable to become registered as a nurse in New Zealand.

People use social capital when contacts or networks enhance power in a particular field. Bourdieu refers to this as "friends in high places" or "old boy" networks. Social capital can be related to the term "it's not what you know; it's who you know," meaning you can be in an advantaged position if you know the right people (Bourdieu, 1977; Crossley, 2005). In relation to the ORN working in ARC, knowing the manager may provide social capital which may give them the cultural and social power to gain an RN position in the future.

Symbolic capital comes from prestige or reputation; it may not be transferable from one field to another because of the attributes valued in different fields (Bourdieu, 1977).

Symbolic capital can also come from being famous for instance, the capital a royal family has been established, because they are who they are. This symbolic capital gives a royal family symbolic, cultural, and social power over the commoners in society. Symbolic capital can also be negative in some circumstances (Bourdieu, 1977; Garrett, 2013). For example, some names in society are associated with bad history and therefore a person with that name could be disadvantaged.

The central focus of Bourdieu's study of the social world is how individuals and groups work towards gaining capital to improve their position in a field (Swartz, 1997). The field becomes the study area, and the researcher should examine the field in relation to other fields (Bourdieu, 1979, 1984). Agents use capital to negotiate for position and balance in the field. Consequently, how agents transform capital can be studied, revealing social hierarchy and power interplays (Bourdieu, 1979, 1984; Rhynas, 2005). Power interplays can be positive or negative. The maximization of all forms of power and the resulting domination inflict inequities which are crucial to study to enact change (Bourdieu, 1977, 1990).

The habitus requires an understanding of the rules within the field and thus can be studied, revealing the hidden strategies used to gain different forms of power. Bourdieu (1985) argues that capital no longer of value in a field may result in a loss of power, and agents may need to convert capital to regain position. The concepts of reproduction and reconversion are used without thought to gain power. Revealing these strategies exposes the hidden, unconscious logic of the field (Bourdieu, 1990) An explanation of the concepts of reproduction and reconversion follows.

### **Reproduction**

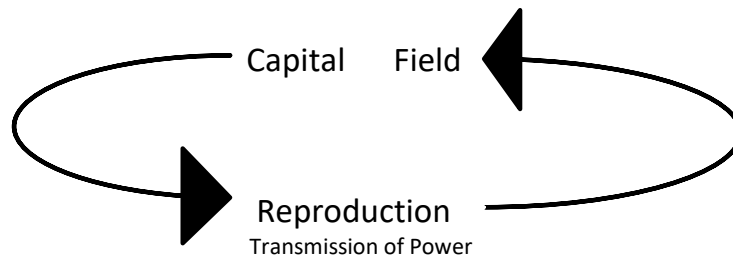
Reproduction is the distribution of cultural capital from one generation to another (Bourdieu, 1998). It can include the passing on of knowledge and experience, and class power or privilege in society (Figure 2). Bourdieu (1998) explained that families use reproduction strategies to continue customs, values, and behaviours. These are pivotal to upholding social order, a vital component of the field. Reproductive strategies also include family investment in the next generation economically, educationally, and matrimonially (Bourdieu, 1998).

Cultural reproduction is a form of social reproduction where groups engage in strategies to produce and reproduce the collective conditions (Swartz, 1997). The collective can be a biological family, or a group unified by a similar habitus, such as an educational institution (Bourdieu, 1998). The accumulation of cultural capital from generation to generation becomes the dominant habitus. A group from a non-dominant habitus must gain the

cultural capital to “play the game” (Bourdieu, 1977; Harker et al. 1990). Whether used by individuals or in groups, all reproductive strategies are ways of maintaining and improving position in the field in the future (Bourdieu, 1984).

Figure 2

Representation of Reproduction



### Reconversion

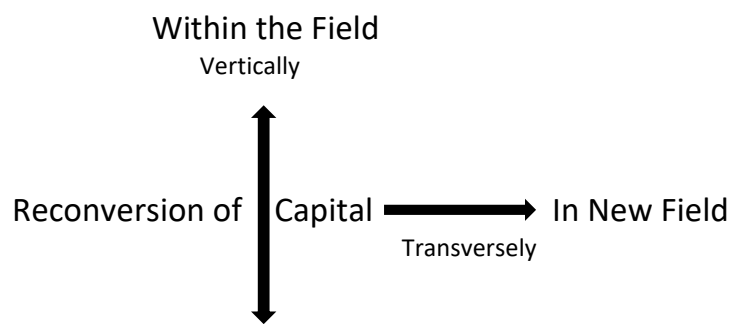
Reconversion strategies are when one type of capital is converted into a different kind of capital to produce changes in position in a field. An example is converting economic capital to cultural capital, such as having the money to buy a required text book, or an education. Bourdieu (1984) explains movements in the field as vertical, upward, or downward in the same field, or transverse, which are movements into another field (Figure 3). Upward movements require capital accumulation within the field; for example, a nurse being promoted to nurse manager due to attaining a post-graduate qualification. Downward movement may occur when a qualification is not recognised within the field, for example, the ORN who is unable to practice as an RN in New Zealand.

A trajectory is defined as the path taken over time, often upward in terms of career moves and social class (*Merriam-Webster Dictionary* n.d.). Bourdieu (1986a, p.215) described trajectory as “a series of successively occupied positions by the same agent (or the same group) in a space which itself is constantly evolving and which is subject to incessant transformations.”

When Bourdieu wrote this, he was discussing writing a biography, a life history, where he explained that understanding trajectory required comprehension of the possibilities within the field where the trajectory would be progressed. In relation to this research topic, capital reconversion enables the overseas registered nurse to work in aged residential care as a health care assistant. However, this is a downward trajectory which is analysed in this study.

Figure 3

Representation of Reconversion



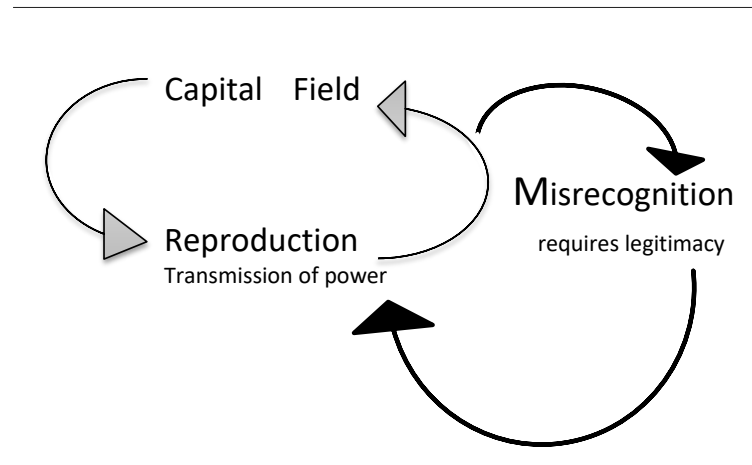
### **Misrecognition**

Misrecognition is a significant concept for Bourdieu and explains how people reproduce inequalities in everyday lives without realising it (Webb et al., 2002). Misrecognition occurs in all fields as people go about their lives disregarding dispositions or habitus and not thinking about how this is maintaining and reproducing social order in the field (Bourdieu, 1977). One explanation of the concept of misrecognition is the example of male domination over women, as women accepted this as the natural order of things. The acceptance of male domination by women affirmed women's position in society (Figure 4). The dominance men had over women was "misrecognised" and was determined to be symbolic violence by Bourdieu (1977). The position of women in society is then reproduced generation after generation (Figure 4). Bourdieu et al. (1999) suggested that when symbolic violence becomes the natural order of things (misrecognised), individuals accept this as logical, and this view is often imposed by broader institutional practices.

Consideration of misrecognition is significant in this study because data may reveal taken-for-granted aspects that influence the practice of ORNs working as HCAs in ARC. Studying this concept may reveal situations of stability and social reproduction as well as disturbance of the doxa (Webb, 2015).

Figure 4

Representation of Misrecognition



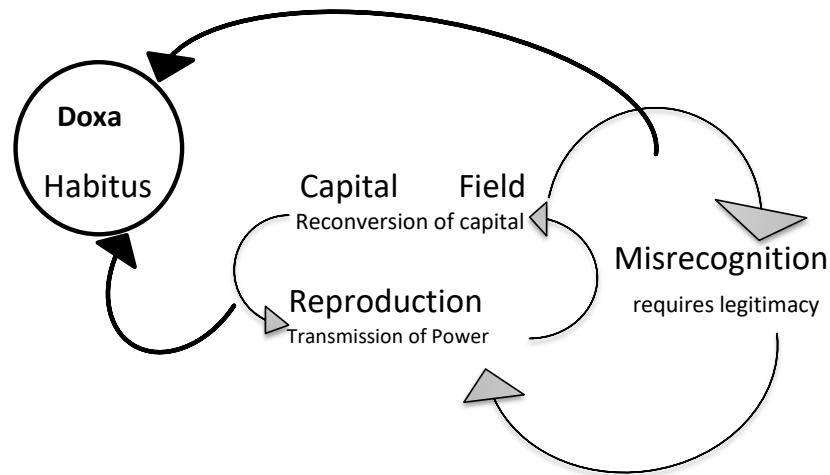
## Doxa

Doxa is part of habitus and contains the realms of reproduction, misrecognition, and the struggles for capital accumulation (Figure 5). Doxa is when these concepts meet and habitus is formed (Harker et al., 1990). Bourdieu (1977) introduced Doxa, differentiating it from orthodoxy and heterodoxy and referring to it as being produced by objective structures but experienced as the usual way of things. Created by the dominant group, Doxa represents itself as the collective perspective of the “way things are” in everyday life (Bourdieu, 1998). Doxa is the undiscussed, hidden practices of everyday life that are generally arbitrary and taken for granted. However, these hidden practices are part of the reproduction of practices that are misrecognised and shape society (Deer, 2014). The Doxa is known to those familiar with the field or those with a similar habitus. The Doxa can unknowingly materialise as symbolic power used by those experienced to gain power over those new to the field or with a different habitus (Deer, 2014).

For ORNs moving to a new country and field of practice, the undisclosed, hidden practices, which are Doxa will be unknown. The ORN in this situation may be the subject of symbolic violence. The following section will discuss symbolic violence.

Figure 5

Representation of Doxa

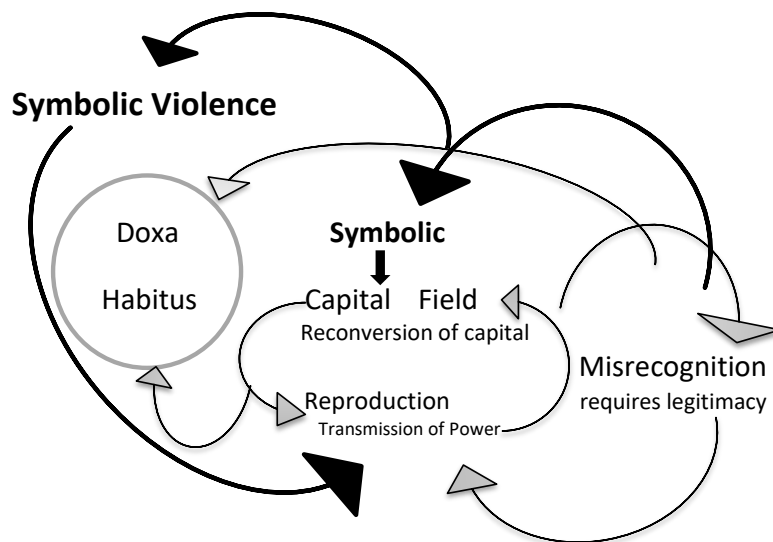


### Symbolic Violence

Symbolic violence is the dominance and power of one person or group over another. It is part of Doxa, most often accepted as “the way things are” (Figure 6). Bourdieu and Passeron (1977, p. 4) defined symbolic violence as ‘every power which manages to impose meanings and to impose them as legitimate by concealing the power relations which are the basis of its own specifically symbolic force to those power relations.’ Meaning symbolic capital, gained from converting other forms of capital (economic and cultural), augments recognition. The recognition of capital legitimises status, provides power, and is the basis for domination. The domination is misrecognised by those taking part. As previously stated, male dominance offers an example of men’s power over women, which has been misrecognised and accepted as “the way things are.” Recognition of this dominance by women as acceptable, gives legitimacy to the symbolic violence it induces.

The literature reviews completed for this study showed migrant nurses are a vulnerable group, often undervalued and subject to discrimination due to societal power relations. The broader fields of power such as NCNZ, Immigration New Zealand and tertiary education providers are the dominant forces; as a result, ORNs find themselves working as HCAs. Symbolic violence could be significant in this study as ORNs accept “the way things are,” which is not being able to register with the NCNZ easily, being on a temporary visa, and accepting work in a lower-level job. Symbolic violence may further prevail due to the loss of symbolic and cultural capital, no longer holding the title of RN in the workplace, and unable to use knowledge, skills, and experience leading to brain waste. Consequently, ORNs as HCAs lose symbolic and cultural power, meaning they are disempowered, and the field becomes an arena of struggles for power.

Figure 6  
Representation of Symbolic Violence



### Power as capital

Bourdieu recognised that possession of economic, symbolic, cultural, and social capital establishes different forms of power as capital becomes “objects of struggle” (Swartz 1997). Those forms of power, for example economic, symbolic, cultural, and social power

are inter-relational and dynamic. Bourdieu (1984) argues that having power does not necessarily mean the owner has power over another. Central to Bourdieu's Theory of Practice is how individuals and groups accumulate and reconvert capital to gain different forms of power to maintain or enhance their position in the field (Swartz, 1997).

### **Bourdieu's Theory of Practice and Nursing**

For Bourdieu, a profession is a socially constructed field of struggles where there is competition over symbolic capital in a larger field of symbolic and cultural power. Nursing has struggled in the broader healthcare field for decades, to be recognised as a profession. History tells us of symbolic violence in the profession as nurses, predominantly females, were considered "handmaidens" to Doctors and only acted under their instruction (Mishra, 2015). Setting up nurse registration and regulatory bodies, developing nursing theories and moving to degree-level education, are examples of cultural and symbolic capital accumulation to improve nurses' professional status in a field dominated by the medical profession. This capital is like aces in a game of cards: it is capital distinct to the field and yields different power in the field and as a consequence, the position of agents in the field is assigned (Bourdieu, 1985; Bourdieu, 1987).

A profession, such as nursing, is what Bourdieu calls a class on paper and agents are defined by their position in the field. Assigning a group to a class on paper is a way of categorising them, enabling predictions on practices within the group (Bourdieu, 1985). The nursing qualification gained from India and the Philippines is not directly transferable to registration as a nurse in New Zealand, so this class on paper changes when migrating to New Zealand. The ORN, who is not registered as a nurse in New Zealand is no longer the professional and no longer holds the aces. When the ORN becomes an HCA, their position in the field changes, consequently struggles and tensions will likely arise that are essentially class struggles (Bourdieu, 1985). Classification of agents seems natural in the social world; they have become taken for granted and form part of the doxa (Grenfell, 2014). There is a doxa formed by the broader fields of power, including NCNZ, Immigration New Zealand, tertiary education, and the ARC sector. The authority of these

broader fields of power inadvertently manipulates the journey of ORNs into working in the field of ARC as HCAs.

Nursing knowledge defines the profession from other disciplines such as medical and allied health and it also denotes the difference between nurses and untrained care workers such as HCAs (Hall, 2005). The accumulation of cultural capital that is expected of a nurse includes knowledge and skills such as assessment, care planning, clinical reasoning, technical skills and evaluating outcomes. This cultural capital may seem similar, if not the same, as other professions, as multiple professionals and non-professionals carry out some of the same tasks as nurses (Smith & Parker, 2015). However, the provision of nursing care can extend over hours or even days, which makes it different from other professions that often 'treat' and 'retreat' (Levett-Jones, 2018).

What constitutes a "nursing habitus" could be considered what makes nursing different from other health care practitioners or professions. Nursing habitus is developed partly through knowledge required for the profession; this explicit and tacit knowledge is valuable cultural capital in ARC. Explicit knowledge is taken from many fields, such as medicine, science, and sociology, whereas tacit knowledge is unhidden and cannot always be described (Zander, 2007). Carper (1978) argued that there was a need to examine the way of knowing in nursing to distinguish it from other disciplines. Carper revealed four ways of knowing in nursing: empirics, the science of nursing, aesthetics, the art of nursing, personal knowledge and ethics, the moral knowledge. There has been criticism of Carper's four ways of knowing in the literature, particularly Carper's lack of attention to aesthetics and the art of nursing (Zander, 2007). More recently, Chinn and Kramer (2018) argued for an additional fifth "way of knowing" that is emancipatory, knowing which is an awareness of social inequalities and the socio-political context of the nurse and the patient. It is recognising that something is wrong with the way things are, which could be changed. In nursing, the five ways of knowing are all parts of the whole, being interrelated and co-dependent. What makes nursing unique is thinking like a nurse and viewing the world with a nursing lens; no one but a nurse can do this (Gordon, 2002). Learning to think like a nurse demands a critical thinking disposition which requires knowledge, experience, and reflection in the field (Levett-Jones, 2018).

## Reflection

Bourdieu (1977, 1998) acknowledged that the researcher's knowledge and disposition influence the interpretation of the experience being studied. This recognition of the researcher's influence led to Bourdieu's passion for researcher reflexivity, which aims to bring the researcher's unconscious influence to a conscious level (Bourdieu, 1977; Costa & Murphy, 2015). In this study, the researcher will be guided by Bourdieu's work and use reflexivity to acknowledge their influence on interpreting the experience of ORNs who work as HCAs in ARC in New Zealand.

## Personal Reflection

This section is a reflection on the chosen theoretical perspective and methodology.

*I am part of a system that disempowers people (as a white European) – the system I am part of (tertiary education) is putting the ORNs in a situation where they have to work as an HCA (reproduction in society) (Bourdieu & Passeron, 1990). The system is not purposefully putting ORNs in this situation, the ORN has a choice. Still, the system unknowingly has a hand in the down-skilling and misuse of the ORNs' knowledge, skills, and experience.*

*Opening up more places for ORNs to study in programmes that do not lead to nursing registration will not bring equity to all classes; it is counter-productive. These ORNs lack the cultural capital to become Registered Nurses in New Zealand. Coming to study in New Zealand on a program that does not lead them to registration as a nurse may give false hope and lead them to take a less skilled job (theoretically). Bourdieu et al. (1999, p 185) state, "Destined by their lack of cultural capital..... these young people are placed in positions likely to raise their aspiration." Bourdieu et al. suggested that there were no guarantees that workers taken away from manual labour to attend school would succeed, and perhaps they were being set up to fail. I feel it is similar for the ORN who travels to New Zealand without the cultural capital to register as a nurse. They have no promise of an RN position or that they will succeed in gaining a post following completion of a CAP. Dominant culture uses dominant groups and social structures to promote values and*

*beliefs which reproduce class position (Bourdieu, 1992; Bourdieu et al., 1999). Universities and polytechnics recruit ORNs to be students before meeting the criteria to become an RN in New Zealand, thus reproducing class positions. This is an example of misrecognition as Bourdieu (1977) described as inequalities produced without those involved realising it. How Bourdieu's theory of practice reveals inequalities, provides reassurance for me that this is the most suitable methodology for this research.*

## **Conclusion**

This chapter has outlined the research methodology used to guide the research, asking the question, "What influences the practice of ORNs working as HCAs in ARC in New Zealand?" The Theory of Practice provides a framework to study everyday actions in the social world and how a person's background, culture, and past experiences influence these actions, (Bourdieu, 1977). The concepts within the theory of practice, such as reproduction, reconversion, misrecognition, and symbolic violence, enable the researcher to reveal hidden practices that are the field's habitus. These hidden practices become the Doxa, "the way things are," accepted by the dominated. Revealing everyday actions that are practice will provide a better understanding of the influences on ORNs working as HCAs to be better able to support them in their transition to being recognised as an RN in New Zealand.

## **Chapter Four - Research Methods**

Chapter four outlines how the researcher undertook the study, starting with the ethical considerations and the approval process required to proceed. The methods used to select and recruit participants and data collection are provided. The analysis was guided by Braun and Clarke's (2006) and Braun's (2019) thematic analysis process, and how Bourdieu's theory of the practice and three levels of analysis supplied the lens to interpret the data are explained. Methodological rigour throughout the research study is discussed using the framework by Lincoln and Guba (1985).

### **Ethics**

Auckland University of Technology Ethics Committee (AUTEC, 18/47) provided ethical approval for this study (Appendix A). Toi Ohomai Institute of Technology Ethics Committee agreed to the research proposal as the researcher's employer (Appendix B).

### **Ethical Considerations**

The Treaty of Waitangi/Te Tiriti O Waitangi principles of protection, partnership, and participation were used as a framework to guide ethical considerations in this study. The Treaty of Waitangi is a document signed by representatives of the British Sovereignty and the Māori chiefs in New Zealand in February 1840. The Treaty is now thought to be of central importance in New Zealand history and has played an essential role in the relationship between New Zealand government and the Māori people. Māori are the indigenous people of New Zealand. The treaty's three principles (protection, partnership, and participation), derived from the beliefs of the Treaty, are widely used, particularly in the health sector, to support good outcomes for the Māori people (Nursing Council of New Zealand, 2011). The Treaty of Waitangi principles are now considered highly important in helping all cultures across society in New Zealand; hence they are appropriate to use to guide the ethical considerations in this study.

### ***Protection***

The researcher is responsible for protecting participant rights, and this was ensured by including the identification and management of potential issues in the research design (Munhall, 2007). Issues considered in this study were risk versus benefit, anonymity and confidentiality, informed consent, and the relationship between the participants and the researcher. Informed consent processes may not be familiar to migrants from Asian countries. Because of concerns about their immigration status, they may be reluctant to sign documents (Lu & Gatua, 2014). The consent process included how confidentiality, anonymity, and privacy were assured (Townsend et al., 2010). Participants were informed that a transcriber would be used. Data would not be stored on the transcriber's computer but on a data storage device (memory stick) and kept in a locked filing cabinet along with all documentation related to the study. Documentation and the memory stick will be destroyed six years after the final report is written. Interviews were held in a private place mutually agreed upon between the participant and the researcher; this included the participant's home, a quiet room in the local library, and the Toi Ohomai Institute of Technology campus. The participants were assured that their employment or visa would not be at stake as the researcher would ensure anonymity, and their identity would not be revealed to their employer. Anonymity from those other than the researcher was maintained by ensuring that personal identity was not revealed in any recorded or written documentation, including the final thesis and any publications resulting from the study.

As mentioned previously, migrant workers are potentially a vulnerable group, therefore, this research excluded participants currently studying programs taught by the researcher. According to Orb et al. (2000), acknowledging the participant's vulnerability at all stages upholds the principle of justice.

### ***Participation***

Participation includes ensuring that participants, who are volunteers, are fully informed, can ask questions about the study, and understand the right to withdraw at any time (Houghton et al., 2010). This information was included in the Participant Information Sheet (PIS) (Appendix C). According to Lu and Gatua (2014), challenges include gaining trust and understanding cultural and language differences. Ganga and Scott (2006) argue

a researcher from a similar background may gain a greater understanding. The researcher is an ORN but is European and as participants in this study are from Asian countries, differences were considered to support and acknowledge their culture. An amendment to the ethics approval was sought to give the participant a choice to have a support person present at the interview when it became apparent that Filipinos were not responding to advertising for participation (Appendix D). Participants were given the opportunity to review transcripts and consent for their interviews to be used in the analysis. A summary of the study's results was sent to participants, and they were asked to comment on interpretation, ensuring their participation throughout the study.

### ***Partnership***

Regarding the Treaty of Waitangi principles, partnership means relationships must be based on honesty and respect and benefit the participants. A power imbalance between researcher and participant can create an ethical concern, and therefore needs consideration. The researcher in this study is an RN and a Lecturer in nursing; seen as higher in the hierarchical structure than an ORN, who came to New Zealand as a student and is subsequently working as an HCA. This power imbalance has the potential to affect the research. By making an effort to ensure the participants feel comfortable without making them feel that they have no choice but to participate, the idea of equality can be established (Karnieli-Miller et al., 2009). Giving the option to participants of where and when to meet, spending time ensuring they understood the Participant Information Sheet and answering questions before the interview, demonstrated a partnership between the researcher and the participants. The aim was to foster a relationship built on honesty, trust, and openness to enable the participants to feel safe to share their experiences.

In summary, the Treaty of Waitangi principles of protection, participation, and partnership guided this study's ethical considerations. These principles were adhered to during all phases of the study, which is demonstrated through reflection by the researcher.

### **Participant Recruitment**

Participants were recruited from the Bay of Plenty and Waikato regions via advertising at Toi Ohomai Institute of Technology, where the researcher worked as a Lecturer in

Nursing. The researcher thought that the college might be perceived as a “safe” place for participants, away from their workplace where, as literature has shown, they may feel vulnerable and unable to speak openly (Stuart, 2012). Advertising for participants involved using posters around campus and online forums (Appendix E). Two of the participants were wives of students at the college. They had travelled with their husbands, who were studying at a post-graduate level, and therefore were eligible for a family visa to come to New Zealand. Filipino ORNs did not volunteer initially. For this reason, amendments were sought for ethical approval to advertise on the Filipino Nurses Facebook page, and for participants to be able to bring a support person to the interview should they wish to. Approval was granted by AUTEK (Appendix D), and subsequently, three Filipino nurses were interviewed. None of these three chose to bring a support person with them.

### **Participant Selection**

A purposive sample is one where the researcher chooses participants according to inclusion and exclusion criteria. This means participants will have the rich depth of experience in the field of study to provide the data needed to answer the research question (Greenfield & Greener, 2016). A purposive sample of 11 participants was selected using the following inclusion criteria:

- ORN not yet registered with the NCNZ
- English second language
- Able to hold a conversation in English about their practice
- Worked in ARC for at least six months as an HCA
- Initiated the process for registration with the NCNZ

These inclusion criteria were chosen because the ORNs who have English as a second language are those nurses who may face challenges in gaining registration with the NCNZ and therefore are working as HCAs. To ensure that the participants had established themselves within the role of an HCA and could articulate their practice, at least six months of experience as an HCA was a criterion for inclusion. It was also vital that they

could hold a conversation about their practice in English, to enable the data to be analysed by the researcher as an English speaker. For this study, ARC included rest homes, hospitals, and dementia care facilities for older people. Initiation of NCNZ registration meant they could perhaps discuss this process in terms of the broader fields of power influencing their practice. The researcher included participants from India and the Philippines to capture the habitus of these heritages because these are the countries of origin of many ORNs in New Zealand (Nursing Council of New Zealand, 2015).

Exclusion Criteria included:

- Any potential participant who was known to the researcher prior to the commencement of data collection was excluded. This included those enrolled-on programs of study delivered by the researcher.

This exclusion criterion was included to reduce risks of power imbalance between the participant and the researcher, who is a Lecturer at the Institute of Technology where some participants were recruited from.

Prior to data collection, participants were sent the PIS via email and given the opportunity to ask questions. The participants were asked if they had any questions about the research and the details of the PIS at the first meeting with them. Further explanation was given where required. Participants signed the consent form (Appendix F) providing informed consent before any data collection began.

## Participant Demographics

Table 1 provides details of the eleven participants who were interviewed.

Table 1

Participant Demographics

Participant Pseudonym	Country of origin	Overseas nursing qualification	Time practicing as a nurse	Overseas practice setting	Length of time as an HCA
Manu	India	BSc Nursing	2 years 7 months	Emergency Department	1 year
Aswathy	India	BSc Nursing	2 years	Orthopaedic Ward	1 year
Rose	India	BSc Nursing	4 years	Surgical and ED	3 years
July	India	BSc Nursing	3 years	Medical and Surgical	6 months
Junu	India	BSc Nursing	4 years 6 months	Surgical ICU and Medical	4 years
Sandy	India	Diploma in General Nursing and Midwifery	2 years	ICU	3 years
Jose	India	BSc Nursing	6 years	ICU India and Saudi Arabia	18 months
Deep	India	Diploma in General Nursing and Midwifery	6 months	ICU – Heart Specialists	3 years
Shay	Philippines	BSc Nursing	3 years	Obstetrics	18 months
Mike	Philippines	BSc Nursing	Over 10 years	Hospital and Home	9 months
Shez	Philippines	BSc Nursing	Almost 10 years	Hospital and Clinic	10 months

## Data Collection

Semi-structured interviews were chosen as the method for data collection with an aim to uncover participant perspectives and allow for further probing and clarification at the time by the researcher (Hughes, 2016). Interview questions (Appendix G) were developed by the researcher using Bourdieu's theory of practice as a framework. Questions were kept open, and the researcher asked for further detail where required to gain a deeper understanding of the participant's practice. The questions began with asking about the

participant's practice as a nurse prior to migration to New Zealand, in particular their practice caring for older adults. This provided an understanding of the personal and professional habitus of the participants and the field where they had been practicing previously. Following this, questions were asked about their practice as an HCA in ARC in New Zealand, the new field. The questions were developed to reveal the field such as "Tell me about working in ARC from your perspective." With Bourdieu's theory of practice in mind questions were asked related to the knowledge and skills (institutionalised and embodied cultural capital) they brought to the field and what knowledge and skills they were able to use in their new role. This included asking how they felt about their new role. The researcher also asked about challenges the participants had when moving to the role of HCA to be able to analyse how they navigated the field and how their habitus changed over time. The interview finished with questions about the new symbolic, cultural, and social capital gained in the role. The interviews were recorded and transcribed verbatim.

Given that Bourdieu (1977) does not advocate for observational studies due to the researcher's effect on the situation, it made sense to use a semi-structured interview approach. The researcher may still have an effect on the outcome of an interview. Bourdieu (1999b, p.610) explains this as the "intrusion effect" as the interviewer asserts questions that will give rise to answers and consequently interpretation from the interviewer's world view. The interviewer occupied a higher place in the social hierarchy as a Lecturer and a Registered Nurse in New Zealand, so this heightened the researcher's power over the situation. Bourdieu (1999b) suggests that by using active and methodical listening skills, the interviewer can go some way to reduce symbolic violence that might be present due to the power relationship. Central to Bourdieu's work is the attempt to overcome the researcher's effect on the situation being studied, as the researcher comes to the study with their own background and dispositions (Bourdieu, 1977). Bourdieu (1977) recommends a reflexive approach to bring the unconscious to a conscious level. A reflexive stance was used to monitor any effects the researcher might have on the interview outcome as recommended by Bourdieu (1999b).

## Reflection

*The first interview was with an Indian lady; I was invited to her home to complete the interview. I took two recording devices with me, which took a while to get going, although I had practiced switching them on and off several times beforehand. The participant was very understanding and accommodating and spoke excellent English. I realised I had to listen and pick up on cues. I needed to interview as a researcher, not a nurse or a teacher. I considered what Bourdieu said that the interview is a social interaction within the constraints of structures set up by the interviewer. Bourdieu (1999b) explains how the researcher starts the game, sets the rules, and makes all the decisions about the interview, so there is an immediate power imbalance between interviewer and interviewee. Adding to the power imbalance produced by social hierarchy can create symbolic violence within the relationship. To lessen this possibility, I attempted to develop a natural conversation rather than following a questionnaire directly, actively listening to pick up on cues where I could probe further. There were some non-verbal cues, such as screwing up her face in a questioning way. I could see at times the participant did not understand what I meant. I felt very conscious that I did not want to put ideas in the participant's mind. I had to choose my words carefully. Bourdieu (1999b) believes this is necessary to prevent bias and to help reveal the respondent's perspective of the research topic. When visiting someone's home to complete an interview, I felt they would control the atmosphere and environment, giving "power" in the game to the interviewee. She introduced me to her husband doing DIY on the house. She offered me a cup of tea and cookies at the end of the interview. She appeared happy, but as if she was trying to please me. I considered why she was trying to please me. Was this her habitus, an ingrained disposition, an attitude that has developed from her upbringing, or did she unconsciously think pleasing me might benefit her in some way; by giving her some social capital in the field of nursing or education (Bourdieu, 1977).*

*Interviewing a participant in a classroom at the college on a Sunday afternoon was very different from being in someone's home. I was responsible for creating an environment where the participant would feel comfortable. Being in a classroom for an interview did not feel ideal; it reminded me of the imbalance of power created in a classroom between teacher and student (Bourdieu, 1977).*

*I accessed the classroom before the participant arrived to ensure it was warm and there was somewhere comfortable for us to sit. I brought two chairs together, so we were not speaking across a table, creating a barrier between us (Greenfield & Greener, 2016).*

*Bourdieu (1999b, p.612) considers the interview as a “spiritual exercise” that aims at changing the way the researcher thinks about the world of the interviewee by creating an atmosphere that will allow for things to be said that may never have been told otherwise. As my control over the physical space was limited (the participant chose it), I used my experience as a nurse to communicate compassionately, using a tone of voice and gestures that led to a more natural conversation rather than an interview. It could be argued that this was a form of social construction in which I, as the interviewer, used my habitus to construct the discussion for my benefit. While I was attempting to reduce the asymmetry in the relationship, I was using the “power” I had as the interviewer to do so. It seems there will never be true symmetry in this kind of relationship. However, Bourdieu (1999b ,p.613) suggested that if the researcher has experience through previous interviews and knowledge of the topic, they can evoke responses that “represent the conditions in which the respondents are placed and of which those of which they are a product.”*

### **Learning through Reflection**

*As I became more experienced in completing interviews, I gave participants more time to think about their answers by keeping silent, not making suggestions, and not putting ideas in their minds. One participant, who had ten years’ experience as an RN in the Philippines, I noticed created his own thinking time by using words like “er” and “now what else?” These pauses indicated that I needed to give him time to think. As a nurse interviewer, I realised time was most often limited, and I would have to gain specific information from clients in as short a time as possible. As a researcher, I had as much time as the participant was willing to give. There was a great deal of non-verbal communication, which was not transcribed, such as laughter or giggling. This laughter could have been a sign of stress or anxiety; I thought there was something he was not sure if he should tell me. Bourdieu (1999b) refers to transcription as a transition from spoken to written that does not capture the true essence of what is being said. Probing questions during the interview helped*

*clarify points. However, the importance of listening to the recordings over and over while reading the transcriptions and taking notes supported the interpretation of what was being said. Due to reflection on the interview experience, I believe the goal to minimise my influence on the outcomes of the interviews was met.*

*Reflecting on insider/outsider influence on a qualitative research interview allowed me to question my position as researcher. I do not have a similar cultural, ethnic, or linguistic background to the participants therefore I would not consider myself an insider. As previously stated, I had an easy passage to being registered as a nurse in New Zealand which already put me in a different “class” to the participants in this study. I am not a cultural insider, and this may have had an impact on the recruitment, meaning participants may have been less likely to come forward because I am culturally different. In terms of my position being a Lecturer with an educational background also positioned me as an outsider. However, I was an overseas registered nurse and I have nursing experience and therefore may have some insider knowledge in relation to this study. While largely being an outsider in the relationship with the participants, familiar connections granted me an insider status at times. This small portion of insider knowledge enabled me to recognise the social differences and power imbalance between myself and the participants. Reflection on this helped ensure effort was made to bridge the power imbalance, however I acknowledge that unequal power- relationships would inevitably remain. One thing that has become apparent to me is that having a little insider knowledge does not make me an insider, it merely helps build rapport and connections to enable the interaction to be more fulfilling, and more likely bring about positive outcomes.*

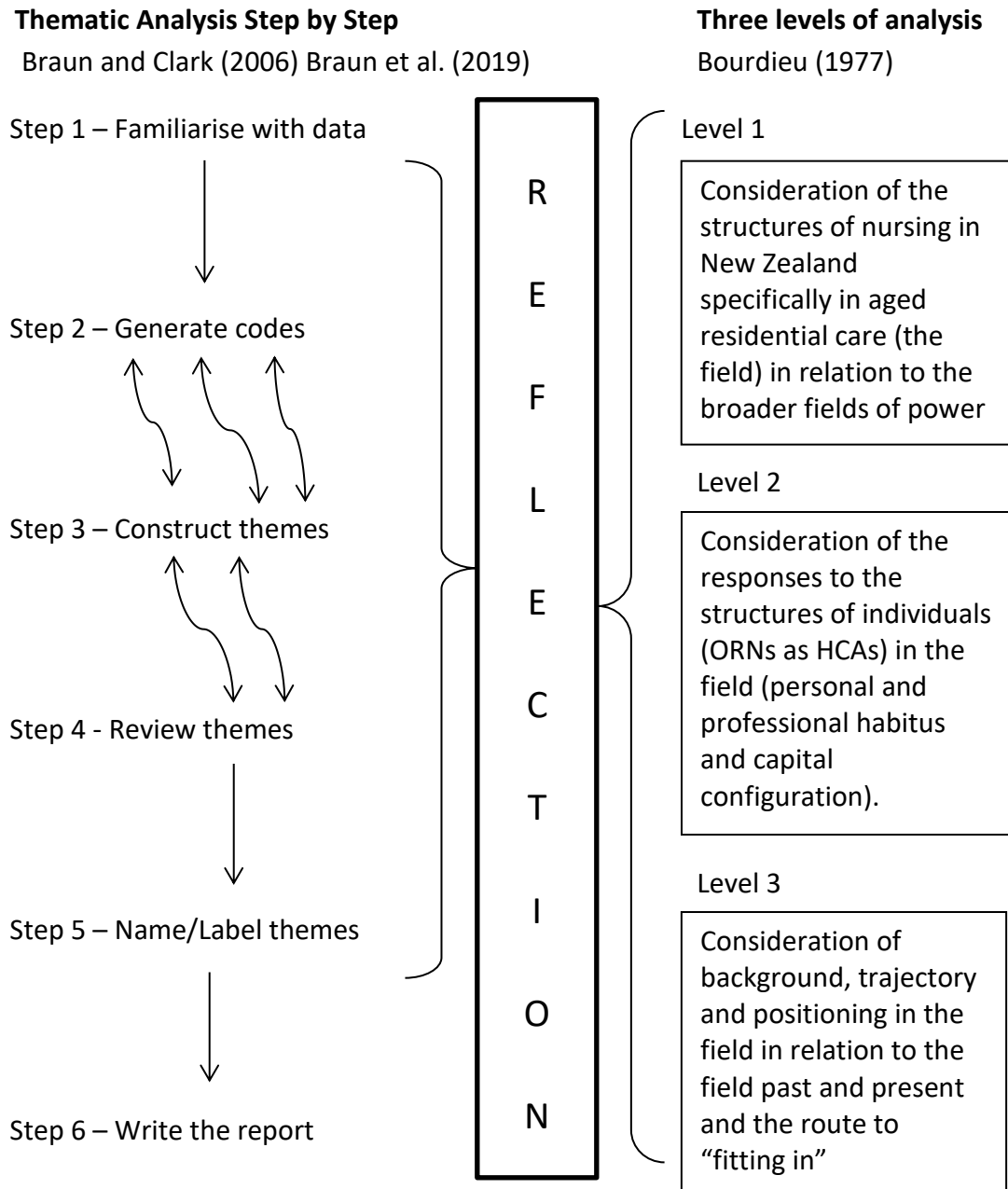
## **Data Analysis**

Thematic analysis using Braun and Clarke's (2006) and Braun et al. (2019) framework provided the process for analysis of the data. Braun and Clarke's thematic analysis was chosen because it is not aligned to any specific epistemology or philosophy, it is flexible and incorporates reflexivity throughout and therefore is appropriate to use with Bourdieu's methodology. A general deductive analysis approach was used to interpret the data based on Bourdieu's theory of practice. This approach is described as a latent level

that distinguishes, examines and discovers the theories and ideologies that are within the data (Braun & Clarke, 2006; Braun et al., 2019). The mode of analysis was by coding and the development of themes to give a depth of understanding of the topic related to Bourdieu's three step approach for analysis (Bourdieu, 1984; Swartz, 1997). Braun and Clarke's thematic analysis process has a six-step approach and was used as a method with interpretation through the three levels of analysis suggested by Bourdieu. Figure 7 shows the nature of going back and forth between steps 2, 3 and 4 of Braun and Clarke's (2006) and Braun et al. (2019) thematic analysis framework and how Bourdieu's three step analysis connects with this framework. The diagram is followed by an outline of how the analysis was undertaken at each step of the framework.

Figure 7

Diagram demonstrating the connection between Braun and Clark's thematic analysis and Bourdieu's three levels of analysis.



### **Step 1 - Familiarisation with data (Braun and Clark, 2006; Braun, 2019)**

This stage involved engaging with the data, which began with notes taken at the time of the interview. These initial field notes documented points that prompted the researcher to return to the subject area later in the interview if required. The researcher wrote further notes following each interview which helped consider aspects that might be significant in future interviews, such as ensuring time was given to participants to think and answer the question. The researcher also recorded descriptions of participant behaviour and mannerisms to interpret non-verbal communication. These descriptions were considered by the researcher in reflective writing. Accurate documentation of actions in the field can help to ensure the credibility of the interpretation (Polit & Beck, 2014). Listening to the recording after each interview, writing notes, and reflecting on assumptions, were completed before transcription (Braun & Clarke, 2006; Braun, 2019)). Simultaneously reading the transcripts and listening to the recordings helped the researcher further immerse in the data.

### **Step 2 - Generating codes**

The researcher undertook the initial analysis, including looking for words and statements in the transcripts that reflected Bourdieu's Theory of Practice, habitus, field, or capital. These were written in the margins of each transcript to generate codes. The researcher read the transcripts repeatedly to ensure all data was considered in the coding. Finally, the codes were written on "sticky notes" with the text's participant number and line number so the researcher could find them again in the transcript. Once codes were generated, the sticky notes were placed on whiteboards and grouped into clusters of similar codes to build potential themes.

### **Step 3 - Constructing themes**

The researcher determined a potential theme, which captured something significant related to the research question, and this theme needed to be represented across the data set (Braun & Clarke, 2006). Once generated, codes were moved around on the whiteboards to cluster similar codes to develop potential themes. Each potential theme

had a central organising concept that reflected capital, habitus, or field and appeared to relate to the research question.

The researcher collated data into an excel matrix related to each potential theme. This collation helped the researcher learn about the robustness and fragility of an idea, and one by one, each potential theme was either accepted or rejected (Braun & Clarke, 2006; Braun, 2019). Coding and developing potential themes gave the researcher some understanding of social position in the field. The researcher wrote reflections in a journal related to this. The structures of nursing in New Zealand, specifically in ARC (the field), were considered in relation to the broader fields of power, as per Bourdieu's level 1 analysis (Bourdieu, 1984; Swartz, 1997). Bourdieu (1977) declared that habitus produces practices that can only be accounted for by considering the structures that reign over them. Bourdieu's concept of "structure" denotes that they act as rules that govern an individual's actions or practice (Bourdieu, 1977).

Bourdieu (1977) level 2 analysis is a consideration of the individual's (ORNs as HCAs) responses to the structures in the field (primary habitus and capital configuration). Codes related to this were generated and written on sticky notes as previously described, and these were moved around on whiteboards to capture ideas for potential themes. The researcher developed mind maps to generate ideas from the data, which signified individual responses to the structures. Identifying the significant structures and the individual responses was also part of assembling the mind maps (Appendix H).

Bourdieu (1977) level 3 analysis considers background, trajectory, and positioning in the field in relation to the field past and present and the route to "fitting in." Data related to changing the position of agents were extracted and grouped to build potential themes.

#### **Step 4 - Review themes**

As the researcher became more familiar with Bourdieu's theory of practice, it was necessary to reconsider codes and potential themes and interpret the data to extract patterns of shared meaning related to Bourdieu's concepts of symbolic and cultural reproduction, symbolic violence, reconversion, misrecognition, *illusio* and *doxa*. This step

included reviewing potential themes, identifying the theme's nature, and checking if there was enough meaningful data to support the theme (Braun & Clark, 2006; Braun, 2019). Reviewing the potential themes meant going back to the coding, moving codes around, considering other potential themes, and grouping them in consideration of Bourdieu's theory of practice and the three-step analysis (Bourdieu, 1977).

Completion of step 4 led to the labelling of themes which is the beginning of step 5 (Braun & Clark, 2006; Braun, 2019).

### **Step 5 - Name and label the themes**

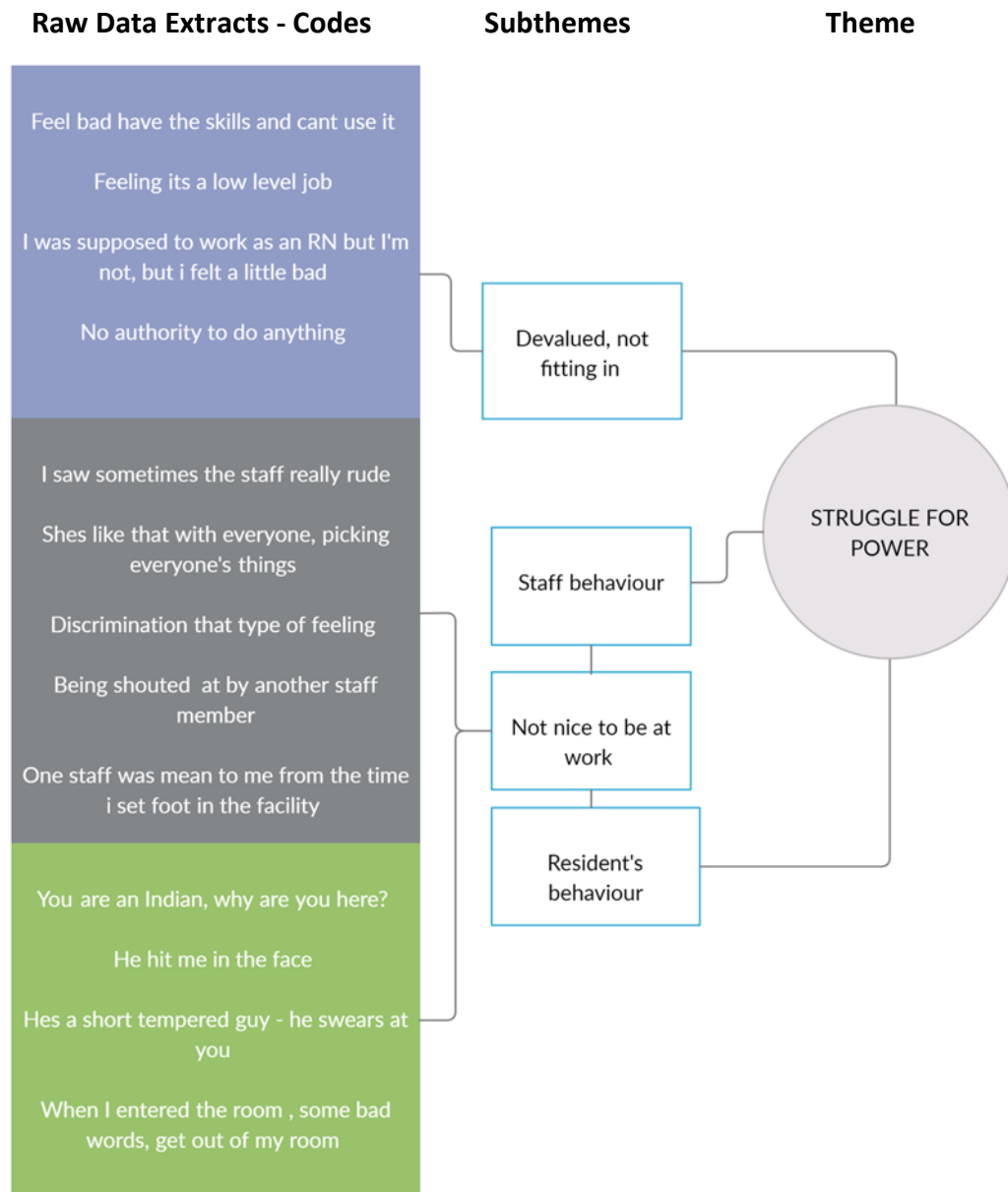
The following is an outline of the named themes and key concepts.

#### **Theme One – Struggle for power**

Theme One Codes (Figure 8) outlines the codes and sub-themes for this theme. The fundamental concept of this theme is the struggle for power in the field as the ORNs working as HCAs are subjected to symbolic violence and are made to feel inferior to their colleagues. The sub-themes drawn from the coding and grouped to form this theme were feeling devalued and not being nice to be at work which related to staff behaviour and resident behaviour.

Figure 8

Theme One Codes



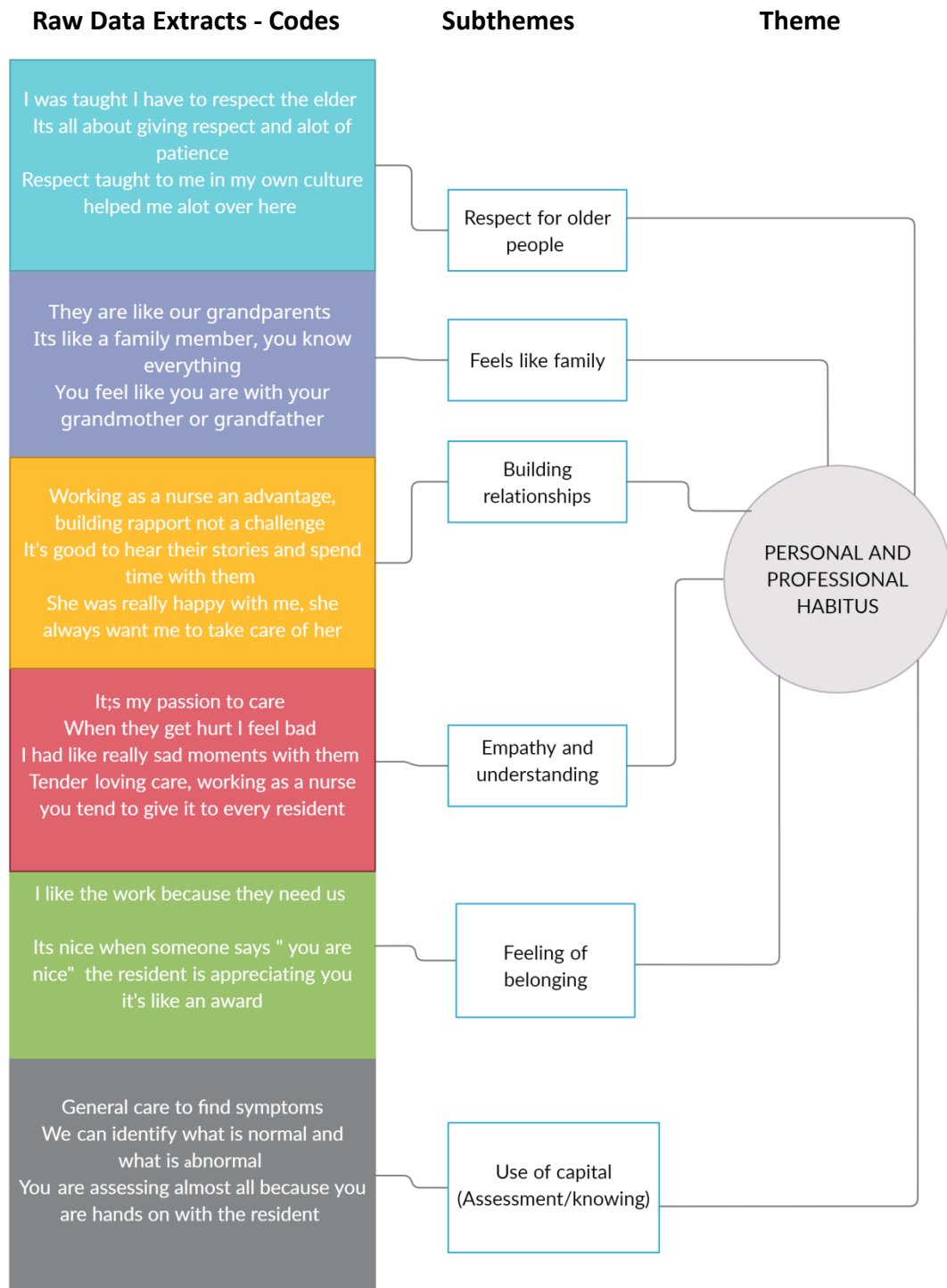
**Theme Two – Personal and professional habitus**

The codes and sub-themes for theme two are outlined in Figure 9. The key concept of this theme is that a nurse's personal and professional habitus is the *raison d'etre* and is taken into the role of an HCA and shown in many ways in the data. Bourdieu (1977) referred to the *raison d'etre* as the subjective sense of meaning when an agent has a “feel for the game.” The theme demonstrates how the ORN uses this “feel for the game” to their advantage. The sub-themes drawn from the coding and grouped to form this theme were

respecting older people, feeling like family, empathy, and understanding, feeling of belonging, and using capital (assessments/knowing). Building good relationships with residents was a potential theme added following the review of codes and potential themes completed in Step 4.

Figure 9

Theme Two Codes

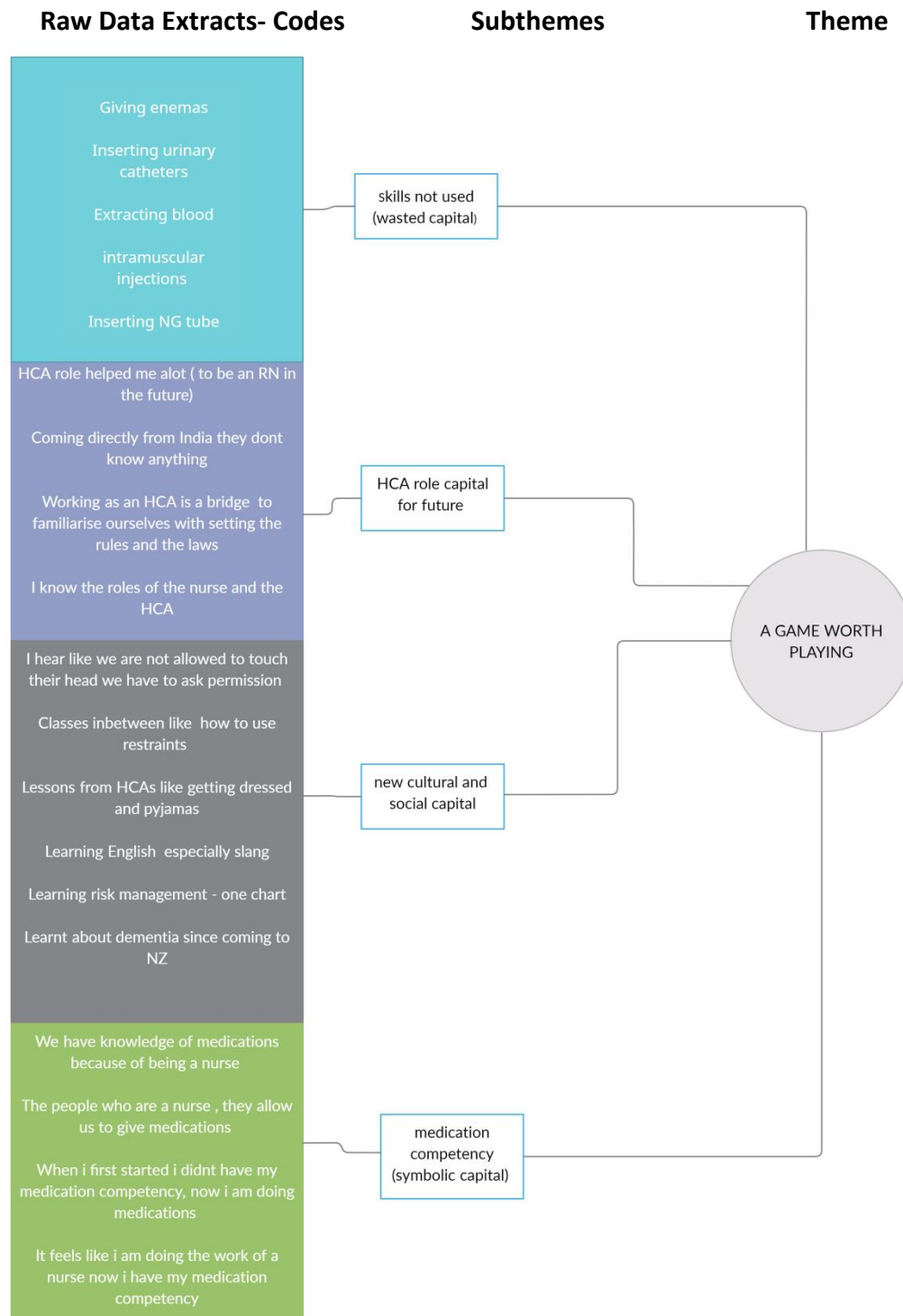


### **Theme Three - A game worth playing**

Theme three considers capital configuration as the trajectory of the ORN as an HCA working in ARC is considered. Sub-themes drawn from the coding and grouped together for this theme were the cultural and social capital the ORN brings to the role, the capital that is devalued and not useful, and the new capital they accumulate in the role. Of particular significance is the completion of the medication competency which evokes power in the field and promotes the HCA to a more senior position in the hierarchy. The capital configuration is seen as “worth it” (Illusio) for their future role as an RN in New Zealand. Codes and sub-themes for theme three are outlined in Figure 10 Theme Three Codes.

Figure 10

Theme Three Codes



## **Step 6 – Writing the report**

Step 6 of the Braun and Clarke (2006); Braun (2019) framework is writing the report and this is presented in chapters five, six, and seven. Prior to this, methodological rigour is discussed.

### **Methodological Rigour**

Rigour in qualitative research has been a debate for many authors over time (Polit & Beck, 2014). The critical issue is that rigour is considered early in the research proposal and at each stage (Dyar, 2022; Thomas & Magilvy, 2011). Lincoln and Guba (1985) have developed a framework of quality criteria, often seen as the “gold standard” for qualitative research, that was used to ensure rigour during this research (Polit & Beck, 2014). The framework is about believability in the truth and interpretation of the data. The five stages of the framework, credibility, dependability, confirmability, transferability and authenticity, are discussed, as each stage is demonstrated throughout the study (Lincoln & Guba, 1985).

#### **Credibility**

There are a number of strategies used to ensure credibility in the research, one most commonly used is recording interviews and transcribing them verbatim (Guba & Lincoln, 1994; Lincoln & Guba, 1985). Recording the interview ensures the words of the participant are captured accurately and allows the researcher to listen carefully rather than having to write during the interview (LoBiondo-Wood & Haber, 2014). Probing occurred in response to participants’ reactions to questions using participants’ own words to extract further detail (Roulston, 2010). During this study, the transcripts of individual interviews were shared with participants to check for accuracy (Greenfield & Greener, 2016). One participant requested to delete part of the interview, because she was afraid the story may be recognised.

#### **Dependability**

Polit and Beck (2014) suggest that accurate documentation throughout can ensure dependability which is the second criterion in the Lincoln and Guba (1985) framework. Documentation was kept at all stages including tracking communication with participants,

participant information, consent, and reflective notes. Dependability also relates to whether the study findings would be repeated if the research were to be undertaken again with similar participants in a similar setting. Member checking is suggested as a strategy to ensure dependability (Polit & Beck, 2014). Member checking involves obtaining the participant's reaction to the interpretation of the data and seeing if they recognise their input in the themes (Polit & Beck, 2014). A summary of the findings and interpretation from this research was sent to all participants asking for feedback, within a two-week period (Appendix ). Having had no replies within this timeframe a reminder and a further two weeks was provided, with no responses from participants. The researcher assumed no responses meant the participants were content with the interpretation of the data.

### Confirmability

Confirmability which is Lincoln and Guba's (1985) third criterion, also relates to ensuring participants recognise their data and that other researchers would interpret the data in a similar way, ensuring researcher bias or views are not reflected in the interpretations (Polit & Beck, 2014). According to Thomas and Magilvy (2011) confirmability requires the researcher to be reflexive, and they suggest that the researcher should document their own feelings and bias following each interview so that they can check later that this does not form part of the interpretation. Reflection is congruent with the methodological approach of Bourdieu (1977) and is used throughout this study. Reflective notes were taken following each interview and were referred to during interpretation to check for unconscious bias. The researcher reflected on positionality and the impact insider/outsider knowledge had on the research.

### Transferability

Transferability, the fourth criterion is about whether the findings can be used (Polit & Beck, 2014). Providing a good description of the participants and the settings used can ensure transferability (Polit & Beck, 2014). In keeping with this recommendation, a description of participants is outlined in Table 1. ARC as the setting is a rest home, hospital or dementia care facility where a person resides to receive 24-hour care, where the

participants had worked as HCAs for at least six months. Further description of the setting was outlined in Chapter One.

### Authenticity

Authenticity is the final criterion of Lincoln and Guba's framework. According to Polit and Beck (2014), authenticity can be achieved when the reader is able to understand more about the lives of the participants, with an appreciation of the emotions and feelings involved, which can be gained by having "prolonged engagement" with the participants. Sufficient time needs to be allocated for the study at each specific stage, including time for each interviewee to truly listen to hear their stories and learn about their experiences (Thomas & Magilvy, 2011). This engagement and time spent with participants is demonstrated in the reflective narratives provided.

### Reflection on Analysis

*From the start to reaching this point has been a long journey and has incorporated multiple layers, going back and forth at each stage, checking, reviewing, thinking, and changing things. When outlining how the project is to be carried out it all seems straight forward enough but now when I look back at each step, I cannot help but wallow in the sense of accomplishment having reached this point. Each step has been a new process, a new learning, and a new achievement. Interpretation of the data from a Bourdieu lens has made me realise and reflect on what I bring to the role of researcher. As the researcher, the choice of topic was influenced by my background. Compared to the journey of Indian and Filipino nurses, I have had an easy ride to working as a nurse and subsequently a Lecturer in New Zealand. While in the role of researcher I can assume to be acting as advocate for those who are less fortunate than me. However, the power I had over the interview and the interpretation of the data creates an imbalance that could be seen to be for my benefit. The prestige and symbolic capital to be gained from undertaking this research is for my own self-interest. Using ethical principles to protect the vulnerability of participants is an effort to tip the balance of power in the participants' favour.*

*As the researcher, I had a central role in the interpretation of the data. My position as an outsider with some insider knowledge remained unchanged as I transitioned from the*

*designer of the research to the interpreter of the research data. Whilst I positioned myself from a western influence, I have worked and lived in multicultural societies and I believe I have values which cross cultural boundaries such as compassion, integrity, and respect for individuals. This however does not mean I can interpret data from a different cultural perspective. My interpretations were from a western cultural background, shaped by nursing experience and an educational background which included teaching students from multiple societies. Although guided by Bourdieu's theory of practice, this position likely affected the interpretations of the data. Documenting my own feelings helped maintain objectivity. One example was when I documented that the first person, I interviewed offered me tea and cookies, my feelings afterwards were that she may have been trying to please me as it could benefit her in the future. When interpreting the data, I had to put this aside and focus on what she told me about her practice. This reflection then guided me to realising that I needed to step back from the connection I made with the participants when interpreting the data and this was continued throughout the data analysis process.*

*Bourdieu's Theory of practice offers a framework to make visible, issues which are not understood and barely thought about by participants. Having been through the data collection and analysis phase, it was very clear to me I had chosen the right methodology for this study.*

## **Conclusion**

The researcher used the Treaty of Waitangi/Te Tiriti O Waitangi principles of protection, partnership, and participation to ensure the research met ethical principles. Following these principles also helped support rigour as outlined by Lincoln and Guba's (1985) five stages of methodological rigour framework. In conclusion, chapter four outlined the researcher's steps to complete this study.

The chapter outlined the methods used to select and recruit the eleven ORN participants. Eight participants were from India, and three were from the Philippines; all met the criteria, including having worked in ARC for six months or longer as an HCA. While Filipino nurses appeared more challenging to recruit for the study than Indian nurses, the Filipino

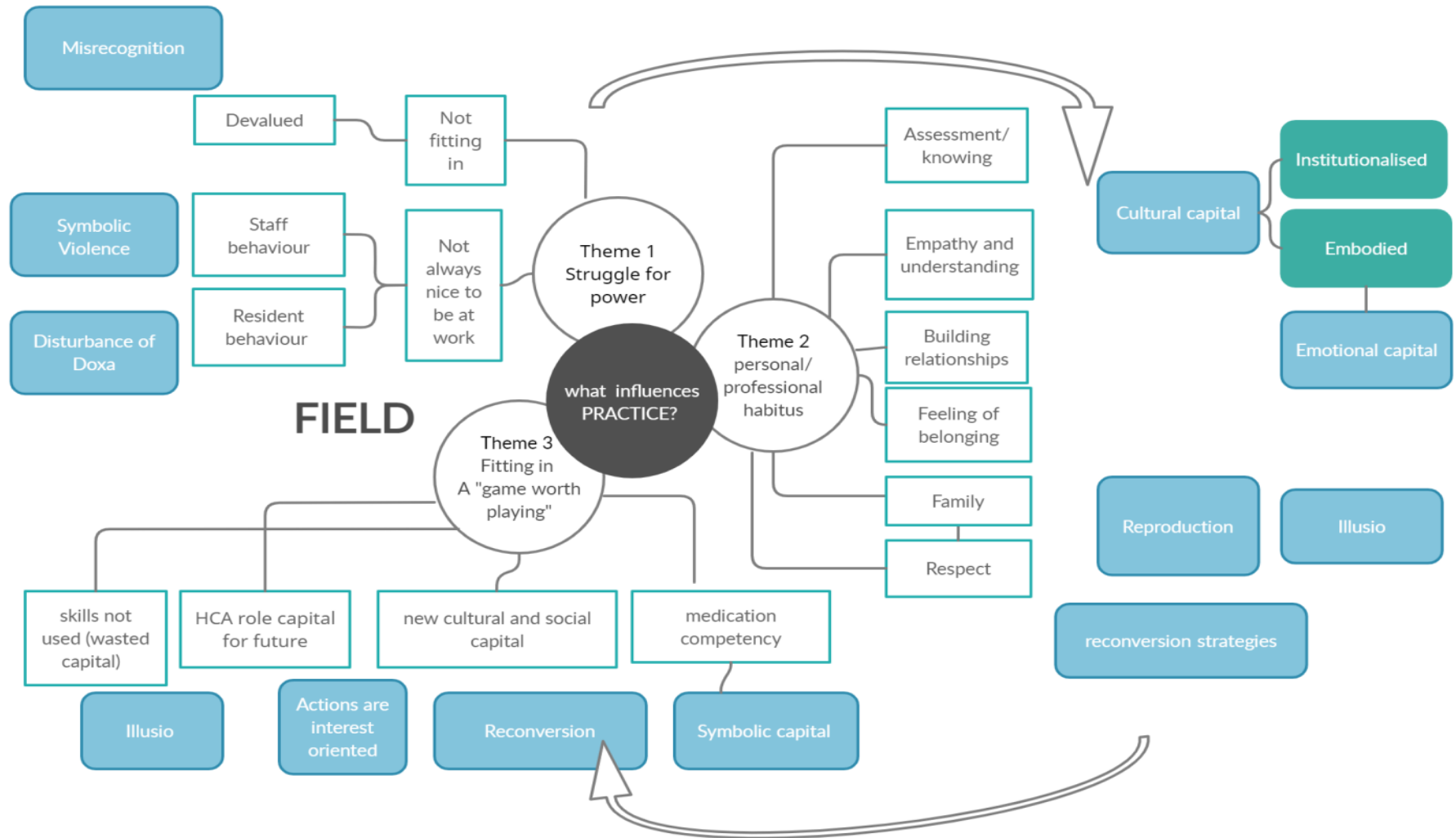
participants chose not to bring a support person to the interview, despite the ethical approval amendment and the offer for them to do so.

The researcher used Braun and Clarke's (2006) and Braun's (2019) thematic analysis process to guide the analysis. A step-by-step approach ensured that the analysis was completed systematically and in detail, allowing the researcher to be immersed in the data. Interpretation using Bourdieu's theory of practice and three levels of analysis is discussed, demonstrating a transparent process in line with the methodology. Reflection allowed the researcher to consider and minimise the effect of the researcher on the data and its interpretation. The analysis process identified three themes: struggle for power, personal and professional habitus, and a game worth playing.

### **Introduction to Chapters Five, Six and Seven - Findings**

The themes identified by the data analysis: a struggle for power, personal and professional habitus, and a game worth playing, are presented in chapters five, six, and seven respectively. Figure 11 Thematic Analysis shows the three themes, the sub-themes and the Bourdieusian concepts that are specifically evident in each theme. Figure 11 is broken into three separate diagrams (Figure 12, Figure 13 and Figure 15) at the beginning of each chapter, to demonstrate the sub-themes and Bourdieusian concepts related to that theme.

Figure 11 Thematic Analysis

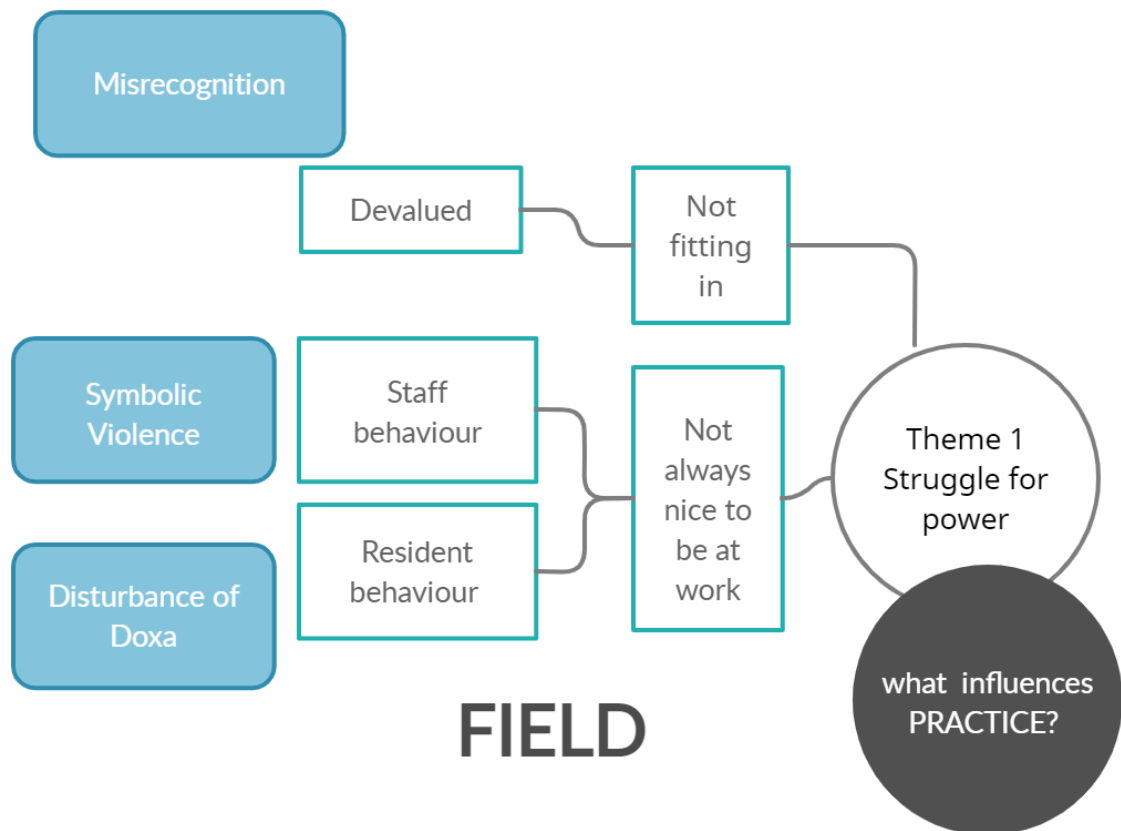


## Chapter Five - The Struggle for Power

This chapter outlines and discusses the theme “struggle for power” as the ORNs working as HCAs are made to feel like they do not belong (Figure 12). Subject to symbolic violence the different types of power become evident, as relationships with staff and residents are fostered. The theme was developed from codes that were grouped to form the sub-themes “devalued” leading to “not fitting in” and “staff and residents’ behaviour” leading to “not always nice to be at work”.

Figure 12

Theme One Struggle for power



As expected, a change of field to ARC in New Zealand from more acute healthcare settings in another country would require adjustment. As well as the change in field the ORN finds themselves in a different role. Knowledge and understanding of the field (how things are done) and knowing the people (staff and residents) is the symbolic, cultural, and social

power held by those experienced in the field and is likely unconsciously sought after by the ORN working as an HCA as the newcomer. For Bourdieu power is assigned by society, both symbolically and culturally and there is a correlation between power held and the position held in a field (Bourdieu, 1989; Swartz, 1997). The pursuit of symbolic, cultural, and social power reveals itself as a struggle for power.

The battle to fit in and the struggle for symbolic, cultural, and social power begins with knowing one's position in the field. Jose, an ORN working as an HCA, showed her understanding that her position in the healthcare field had changed when she said she has *"No authority to do anything, you are a health care assistant, not a nurse."*

This quote acknowledged the position of the HCA as being subordinate to a nurse and therefore having less symbolic power. On one hand, Jose felt she had no authority to do anything in terms of making decisions because she had to report everything to the RN. Contrarily, she felt she was using her nursing skills whilst caring for residents, such as showering and toileting, making them comfortable and, recognising when residents had problems. Jose appeared to struggle with the loss of symbolic power as she stated, *"I use my nursing skills, but I don't have the title."*

Sandy also struggled with the loss of symbolic power as she pointed out she can do some nursing skills confidently, but she is not allowed to because she has not got a certificate of competency in New Zealand. Sandy said

*even though you are a nurse, you have skills, you can do that [nursing procedural skills] very confidently but you can't, you are not able to do that because you are not competent here, you don't have a certificate to do that.*

An authority or certificate to undertake a role provides cultural capital and, in this case, the cultural capital is symbolic because it comes with the prestige of a title or seniority.

Shez explained a situation which demonstrated the struggle for power, as loss of symbolic power meant Shez could not act on her assessment of a resident. Shez had to report the situation to an RN, who did not react the way she expected, Shez stated

*he [the RN] should have seen the patient first before you know, because although it usually happens, it always happens to that resident but, it doesn't mean that we don't check the patient, the resident, so ok if that's what you [the RN] said but, we just inform the other RN.*

Shez understood the responsibility of an RN and her knowledge and experience informed her that she needed to report the situation to a different RN who in Shez's opinion was prepared to act appropriately. Shez knew the situation needed a different response from an RN, because of her change in position from RN to HCA she was not allowed to respond herself. Shez stated "*We practice what we know as a nurse but we set limits as job description.*"

These statements by Jose, Sandy and Shez highlight the loss of cultural power and symbolic devaluation as they no longer hold the title of Registered Nurse, meaning they are not qualified in New Zealand to practice as an RN, as they would have in their country of origin.

Participants spoke of nursing skills they used in the HCA role such as communication, building relationships, assessing residents, and providing personal care. They also spoke about those skills they are not able to use, which appeared to be procedures, such as inserting a urinary catheter, administering enemas and medications. Some participants also spoke about skills they did not have but were expected to have because they have worked as a Registered Nurse, such as handling residents' aggressive behaviour.

The ORN has accumulated practice through experience in nursing prior to working in New Zealand. In ARC they entered new fields with new rules, lost their title, were subordinate to an RN and unable to use some acquired skills, and consequently they were left to feel devalued. The following section presents data and interpretation from the sub theme devalued and not fitting in.

### **Devalued and NOT fitting in**

All the participants spoke about skills they cannot use in the HCA role. Added to the loss of symbolic capital, no longer having the title of a nurse, the ORN is at risk of losing

institutionalised cultural capital by not using their knowledge and practicing the skills accumulated as a nurse; these skills become “wasted capital”. This adds to the struggle for position whilst the ORN learns to navigate the new field and its rules, they must come to terms with loss of identity and deskilling.

Sandy said

*It's bad as you know, you feel very bad, you're like a normal person [lay person] here, even though you are a registered nurse, but when you're working in aged care facility without any competency, you're a normal person as the other, you're tagged as a health care assistant, it's really bad.*

Junu talked about the skills she used as a nurse in India and how the HCA role does not allow her to practice as a Registered Nurse.

*Back in India we have to do everything, blood extraction or a nasogastric tube, or an IV-line, catheter insertion, we have to do, if the blood's taken, we have to take the blood and send it to lab, that's what happens in India, so that's [the HCA role] not meeting my profession.*

Deep described how she felt about the role of an HCA because of how the role is perceived in India and how she is not allowed to use the skills she has accumulated. Deep stated: “It's a bad feeling like I'm feeling it's a low-level job.”

*Like in India nursing profession is like a high standard job, so you are not doing these types of things [cleaning after toileting], they have some type of mentality that's a lower skilled thing, that's a lower-level thing.*

*Yeah, like sometime like nurses are busy, I can tell them but the thing is that you are not allowed to do these things, like sometimes they are really busy, and patients are constipated, I can do like enema, I can do catheterisation, I know everything that type of thing but I can't do, because that's not in my role here.*

Junu and Deep explained that the HCA role was a lower status position than the RN and they are unable to use the skills and practice they have accumulated. They knew they were employed to work as an HCA not an RN. By accepting employment to an HCA position an ORN unwittingly contributes to the reproduction of symbolic violence within the healthcare field. Once in the role, they begin to appreciate the difference between the roles; the loss of identity and the feeling of being devalued is experienced. Working as an HCA prior to registration as a nurse is not a NCNZ requirement, however self-interest drives the ORN. The role of HCA is a means to an end providing financial support for study in New Zealand for themselves or a partner, as well as the potential benefits of acculturation such as language, culture, and practice.

Manu did not study in New Zealand, she joined her husband, who was working as an RN. She was happy initially to work as an HCA because it felt similar to the role of a nurse, but over time she recognised the differences and realised she should be working as an RN. Manu said

*I was very happy to work as a healthcare assistant here, but always I felt like, well back in India I'm a registered nurse and here I'm just a healthcare assistant, and when I saw the other registered nurse, I feel like oh I was, I am also supposed to work as a registered nurse and I'm not, and I felt a little bad..... At first, I was very happy to work, it's like I feel it's exactly almost being like a nurse.*

*Yeah, I feel bad because when I work for 2.5 year as a registered nurse, and it's like many differences as an HCA, so that's why I thought like I have to do the registration, because there is a difference.*

Aswathy travelled to New Zealand with her husband who studied initially and now works as an RN. Aswathy expressed feeling sad about working as an HCA but appeared accepting of the route she needed to take to become an RN in New Zealand.

*You know at first, I was sad because, I'm trained in India but I'm not [here], because I'm not like, I'm not allowed and it's because of me I have to qualify the IELTS and do the CAP course, so I just like keep saying to myself that you have to,*

*like you have to do the IELTS, you have to do the CAP course, after that then you can be a nurse in New Zealand.*

The ORNs in this study cannot work as RNs in New Zealand until they meet NCNZ requirements and have completed a CAP and as they are unable to challenge this, the ORN is forced to accept it. Bourdieu et al. (1999) drew attention to the idea of marginalisation and suggested that when this becomes the natural order of things (misrecognised), individuals accept it as logical, particularly when it is imposed by broader institutional practices such as registration requirements. Seemingly marginalised, the ORNs find themselves in what they perceive as a lower-level job, sad and frustrated struggling for acceptance in the new field. The associated power struggles with staff and residents are challenging and unpleasant, resulting in the ORN as HCA not wanting to go to work. The following section presents data from the sub theme “not always nice to be at work” due to relationships with staff.

## **Not always nice to be at work**

### **Staff Behaviour**

Junu described a situation when a senior HCA (pseudonym Peter) spoke inappropriately to her. She was working with a colleague in one area of the facility, when they were asked if one of them could help in a different area. There was a delay in her going to help out, and she received a hostile welcome from Peter, a Fijian male, an HCA who is not an ORN. Junu said

*He shouted on me, ‘why no one, why you didn't tell, why you didn't send her [referring to the HCA Junu had been working with] over here to help us with the care’, and he was shouting at me, he I mean he's not even giving me time to talk even, and he said ‘what she's doing there is she watching TV or anything?’, I said ‘no she's not watching TV, we just sorting out everything, and one of the residents he was not in a good mood, so we just give them, we give him time and it took a while to finish our care,’ and he's really shouted on me, and that makes me cry.*

The symbolic power interplay in this situation may stem from a variety of differences; gender, ethnicity, and longevity as an HCA in the field of ARC. According to Bourdieu (1989, p. 23), Symbolic power is *“the power to make groups.”* Junu did not belong to the same groups as Peter due to their differences (male, Fijian, experienced HCA). Junu appeared to accept this behaviour when she commented *“No need to complain these things happen.”* By not challenging Peter’s behaviour Junu allowed him to hold the power in the field at this time. She gave him symbolic capital and she misrecognised the hidden agenda for Peter to assert his position in the field. The situation upset Junu and it made her cry but by stating she would not complain, she appeared to accept it as the natural order of things.

Shez described a situation where she expressed a feeling of being bullied and how a staff member intimidated all the new staff. Bullying at work is *“a persistent misuse of power, whether formal or informal. It is ongoing offensive, abusive, intimidating, malicious or insulting behavior”* (New Zealand Nurses Organisation, 2020, Workplace Rights, Bullying section). Shez said

*Well there is this one staff [Janet, pseudonym] , she was so indifferent, she was so well I can say she's so mean to me. From the time I started setting foot in the facility, and I don't get to work with her every day, but some like 2-3 shifts I've worked with her, and then there's one time that, something happened to a resident, where I helped one of the co-worker take care of that resident, and something bad happened, and that lady, thought that I was the one directly involved with what happened, so like I was feeling I was bullied.....it made me feel uneasy, I don't feel working, I don't feel comfortable with working with her.*

Researcher “have you seen that person be the same with other people?”

*Yes, especially to the newbies, yes she's always like that, because after I got into the facility, there are 3 others who also got in, and she also did the same thing, and I said oh ok maybe it's just her way of intimidating the newbies, and because she's already the senior. I was thinking alright maybe she's bullying the newbies, because*

*she might think that these newbies will be a threat on her, I don't know, but I just can figure out that how she treats the newbies, and how she treated me were just in the same pattern.*

Janet's behaviour is in line with the NZNO definition of bullying in terms of it being on-going and intimidating. She consistently used her experience and longevity in the field (embodied cultural capital) as power over newcomers in the facility.

Deep was threatened when she reported the behaviour of an HCA (not an ORN) to her senior. Deep said:

*I saw sometimes staff really rude, which I don't like, because it's not their [the resident's] fault, why you [staff members] are behaving like this, you are here for them [the residents], if you are not caring for them why are you working here? So that type of feeling sometimes comes in my mind, sometimes I'm very upset with these types of things.*

Deep struggled with understanding why a staff member (Tracy, pseudonym) was disrespectful to a resident, so she spoke with her manager, Deep added *"I never keep quiet, I always told to like the senior person, that's not good, so I did that thing, I complained about them"* [meaning Deep complained to her manager about the staff who were rude to residents].

Following the complaint to the manager Deep faced repercussions, she explained

*Face to face that person [Tracy] told to me, 'ok if you are doing this thing to me' [reporting to senior], that time I was new there, like around 6 months, and she told to me, 'if you want to do that to me, I'm going to see you', and that time I cried a lot.*

Deep recognised that Tracy's behaviour towards residents was not appropriate, and when Deep reported her actions to the manager, Tracy used verbal threats to gain control of actions in the field at this time.

Deep added more about how she noticed that some staff were rude, and she implied that she was being closely watched in an intimidating way. *“She [Tracy] just like picking everyone's things, some person at the workplace is like that, they just don't do their work they're just keeping eye on us.”* Later in the interview Deep referred to Māori staff more generally when she said

*Māori person I find they are really rude.....Māori person is like rude, when you meet them, like they are what are you doing, like they have an attitude, they are always talking attitude like..... like that time when I was new here, that time I felt really bad.*

HCAAs that have worked in an ARC facility for a length of time will have experience; they will know the residents well, and they will take a lead in care delivery. They may feel threatened by an HCA that has a nursing background. This tension, compounded by cultural differences, is a struggle for superiority and the ORN as an HCA is left feeling intimidated and believing they do not “fit in”.

In a busy work environment, it may be difficult to make positive connections with work colleagues, especially if those work colleagues are different as the above participants have commented. Sharing stories with work colleagues is important to build relationships and helps to give a social identity and a sense of belonging in the workplace. Feeling of belonging and acceptance in a group (in this case work colleagues) is a central aspect of society (Bourdieu, 1987).

The coffee break or the lunch break might be used to make connections, but it may be difficult, especially if people are from different backgrounds. Some staff members that have been in a facility for a long time will be more welcoming than others, some will not be interested in making new connections, they already feel like they belong and do not need to make an effort with newcomers. The intimidating behaviour described by Junu, Shez, and Deep, are ways a person exerts symbolic, cultural and social power over another and is not uncommon when a person's position in the field is threatened. The field is a space of struggle for position for both the experienced and the newcomer. The behaviour

by the HCA (not an ORN) in Bourdieu's interpretation is symbolic violence; it enables them to maintain dominance over others. For Bourdieu, there is a struggle where the experienced will tend to engage in conservation strategies, and newcomers will more than likely use succession strategies to gain a more dominant position. Conservation strategies are used by the dominant and are actions taken to keep control and position in a field, where as succession strategies are used by those who seek to gain a more dominant position in a field (Swartz, 1997). An ORN working as an HCA challenges the hierarchical order, causes a disturbance of doxa and unsettles the habitus, as experienced HCAs struggle to maintain their position. Doxa is the hidden, unspoken about, continuity of meaning in the habitus which depicts the field's beliefs. The structure of care delivery in ARC is hierarchical as the RN leads a team of HCAs; this denotes a doxa (or a belief) that the HCA is inferior. The symbolic violence towards the ORN reinforces the devaluation and seeks to put the ORN as HCA in an inferior position to the experienced HCA (where they are perceived to belong by the doxa).

Some participants felt some staff members were offensive, which could be their perception because of a difference in culture and language, but whatever reason, the attitude of some staff members make the ORN as HCA feel intimidated. This leads to the ORN as HCA being unhappy in the workplace, frequently evidenced by crying and not wanting to go to work. This situation is heightened if they have difficult relationships with residents too. Some residents do not wish to be cared for by someone from a different country. Some residents are aggressive, and there is an expectation from management that the ORN knows how to handle this behaviour. This escalates the effects of identity loss, feeling devalued, and not "fitting in." The following section presents data and interpretation in the subtheme "not always nice to be at work" because of relationships with residents.

## Not always nice to be at work

### Resident Behaviour

#### *Power of Words*

Some participants described how residents pointed out their racial differences which made them feel like they do not belong in New Zealand. Jose said:

*Some of them [residents] like 'oh you're from overseas country, you should not work here...only New Zealanders should get this job, because a few people there is a lot of unemployment here, you should go back and work in India' I have experienced some of that*

Jose added “they see our skin, he said ‘are you from India? are you from Fiji? you shouldn't work here.” Deep also spoke about residents that pointed out racial differences, saying

*sometimes like the residents, European residents, they have that types of feeling, like you are an Indian, why are you here, we have one resident she's European, she has bipolar disease, so that's why we never like we know that that's her condition, but yeah she's told sometimes that type of thing, 'go you are an Indian, I don't want any care from you', and she used like abusive words too*

The direct communication not only pointed out that Jose and Deep are from another country, but it informed them they are not welcome in New Zealand. Deep acknowledged the verbal attack may be because of a mental health condition, but despite this there is an underlying tone making Jose and Deep feel like they do not belong.

Rose described how some residents made her feel like she does not belong in a more subtle way than direct communication. Rose believed the residents chose not to understand her because of her ethnicity. She explained:

*maybe sometimes they [residents] don't want to understand, like sometimes resident is like that, like if we are talking, they know that we are not from this*

*culture, so they're going to say that I don't understand you, what are you talking about? so we said ok, we will repeat them, but if they're still saying the same thing, so like we are working two person, then I will ask the other person ok can you please explain to her, and but she just going to blame that, I can't understand her, what she is talking about, she said the same thing but she just behaving like you are from different ethnic group. Sometimes they are like that, they will give you like that types of feeling, ok you are not belong to here.*

Rose added

*They don't want to understand me. They understand things but we can know that they're understanding, but the things they are saying that I can't understand you, what you are talking about, I don't know, they just don't want to listen.*

Rose expressed how it made her feel, and how she had to learn to manage these feelings.

She said

*I feel really bad, because it makes us like discrimination, that types of feeling.... we also know that like if you are going in a different country, that type of challenges always come, like you know that, you are from different, yeah somebody want to say these things, so you have to handle, you have to make yourself hard.*

*Like people want to say the things, better to ignore these things, if you're going to feel these things more and more, it's going to hurt you, and it's going to stress you even, you can't do work, if you are thinking about that thing again and again. In the starting I did that thing, like I was thinking what is happening here, why I'm here, what I'm doing here like people are like this here, but I find some nice people too.*

Rose found a way of coping with the discrimination but the power interplay between Rose and the residents is profound. Rose's presence as a person from another country was challenging the doxa, the status quo, the comfortable order of things, powerless and oppressed Rose, legitimises her position in the field by ignoring the situation and making

herself hard. Bourdieu (1977) explains this as misrecognition as power evoked over someone is overlooked and it becomes the natural order of things.

Aswathy explained what happened on her first day as an HCA in ARC when a resident did not want her in his room.

*It was my first day, so it was my day of orientation and my preceptor asked me to give a cup of coffee to one of the residents, and I don't know why he was, maybe in pain or something, when I enter his room he just told that you, just some bad words you get out of my room... I was crying when I went home, so it was my first experience.*

Aswathy was not prepared for this reaction from the resident and whilst she recognised he may have been “in pain”, the situation made her feel unwelcome, and led to her being very upset. She took it that the resident did not want her there because she is Indian.

Aswathy also spoke about a friend, an ORN working as an HCA who had a similar experience. She explained “*he had a bad experience, and the resident’s family told that they don't want Indians to take care of their, their father so he was really upset*”

Aswathy appeared to accept that this is the way things are, which legitimises the behaviour and consequently reproduces the social order which oppresses certain groups.

### ***Power of Aggression***

Some participants also described acts of physical aggression towards them from residents.

Mike explained how he was hit by a resident who was unhappy with the care he provided.

*I remember this difficult client, Māori client that I had, he's the most difficult person I've encountered, he even hit me on the face, yeah so that's how difficult he is, thinking that I'm this kind of person that, I give care as much as I can, 100% to care but I still got this and I just thought I don't deserve that treatment, or anyone doesn't deserve any treatment like that so, they have a strong personality, Māori people so it's quite a challenge.*

*Because he's very particular in his care like, he wants these things done properly, he has a very low or short tempered guy, he gets agitated easily,..... if you've done something wrong he swears at you, it's like that so, I already knew that he's going to hit me, or he's really pissed off already, and I tell everyone that it's ok, it's my fault I didn't duck, yeah because I knew it was coming.*

*I'm alright, because I knew it was just a burst of emotion, because he's frustrated and he's, because as a nurse you understand how the situation is for them, how frustrated are they on their situation.*

Mike acknowledged that no one deserves being hit on the face; he is able to cope with this situation using humour (saying “*I didn't duck*”), and he showed an understanding for the resident's situation. There is a struggle for power as the resident uses aggression towards Mike to gain control. Mike reported the incident to the Nurse Manager but chose not to report it to the police; he believed it was his fault, thus condoning the behaviour. There appeared to be an acceptance by Mike as if it was just part of the job, and the natural order of things. This acceptance is misrecognition of the inequalities and the struggle for control between residents and the ORN as an HCA.

Sandy explained how she did not know how to handle residents who were aggressive and how as an HCA, she only expected to be supporting them with activities of daily living. This caused her to not want to go to work.

*On that day I don't know how to handle her, and she scratched me very badly, so then but after that my team member, they help me a lot, my manager came here and her family, she apologised, her daughter in law she apologised from her side, so that's the experience when I get injured from my resident because of unknown strategy, because I don't know what to do that time.*

*I never even thought that I will like, I will like care for those people who are very aggressive, I have no idea how to deal with, that's the only thing, I was thinking on that time I'm going to do, like the daily things for them, like I have started in here we have to do their, we have to assist them for their daily basic care and all that*

*thing, I was thinking that's the only thing, I don't know that I have to face the challenges as well, so that's the thing that I haven't think about.*

*I feel, like you know when you're working with challenging person, you also feel frustration, you don't like to work, go on work the next day.*

In this situation there is an additional tension, as Sandy was expected to know how to handle an aggressive resident because she is a qualified nurse in her country of origin, and she was left alone to manage the situation.

Jose was also expected to manage challenging behaviours from residents, as an HCA on duty on an afternoon shift with no RN on site, she asked to change shifts but was told she should learn to manage the behaviours of residents. The facility provided a level of care where an RN was not required to be on site 24 hours a day, therefore as an HCA Jose felt unsupported.

*I actually cried so many times because I couldn't manage her, she was like taking every 20 people at the door and knocking at the door, and we're really busy, and they're physically active, I couldn't manage because all these 20 peoples and we were 2 staff. Couldn't even get inside the rest home because of them, I can't take care of other residents because of them, she's coming with demands, she's pressing the alarms, calling the ambulance, she's doing every sort of stuff that she can do, she could do. I actually asked the manager, can I have a morning shift, she said no you should learn to manage these behaviours, so I continued the afternoon shifts.*

Jose left this job soon after, because she found her position intolerable as both resident and manager held the power and she did not have the cultural capital needed and struggled to adapt to the situation.

Mike, Sandy and Jose's situations were similar in that aggression was used by residents to gain autonomy and independence (power). Mike used humour to cope, Jose and Sandy were emotional, felt upset and did not want to go to work. Perhaps there is an underlying assumption by managers that an ORN should know how to handle aggressive behaviours

from residents. Aggressive behaviour from residents is unexpected by the ORN and not knowing how to handle it can lead the ORN struggling further with their identity and how they “fit in”.

## **Conclusion**

People who occupy the same position in a field, have every chance of having a similar habitus, at least in so far as the trajectories which have brought them to these positions are themselves similar (Bourdieu, 1987). The trajectory for HCAs working in ARC in New Zealand differs. As ORNs, the trajectory includes education, training and working as a nurse, which is a very different trajectory to that of the HCA who is not a qualified nurse. The ORN as an HCA has a habitus of a nurse, the HCA who is not a nurse has a habitus developed from their culture, background, and longevity in the field. The difference in turn, creates tension or power interplay between staff groups. Compounding this tension are residents who are often racist and abusive, refusing to be cared for by the ORN as an HCA because of their ethnicity. As well, there is, an expectation by managers, that an ORN should know how to handle challenging, often aggressive behaviour. As a consequence, the ORN as HCA amidst the struggles for power lose their identity, often feel like they do not “fit in” and do not want to go to work.

A field is a social space in which people struggle for position and acceptability. It is a field of forces driven by capital which is of value in the particular field, which in turn is related to the cultural and social characteristics of the habitus (Bourdieu, 1984). The struggle for position and recognition is ultimately central to social life as people go about their business unaware of their use of reproduction and reconversion strategies to gain power (Bourdieu, 1984; Harker et al., 1990).

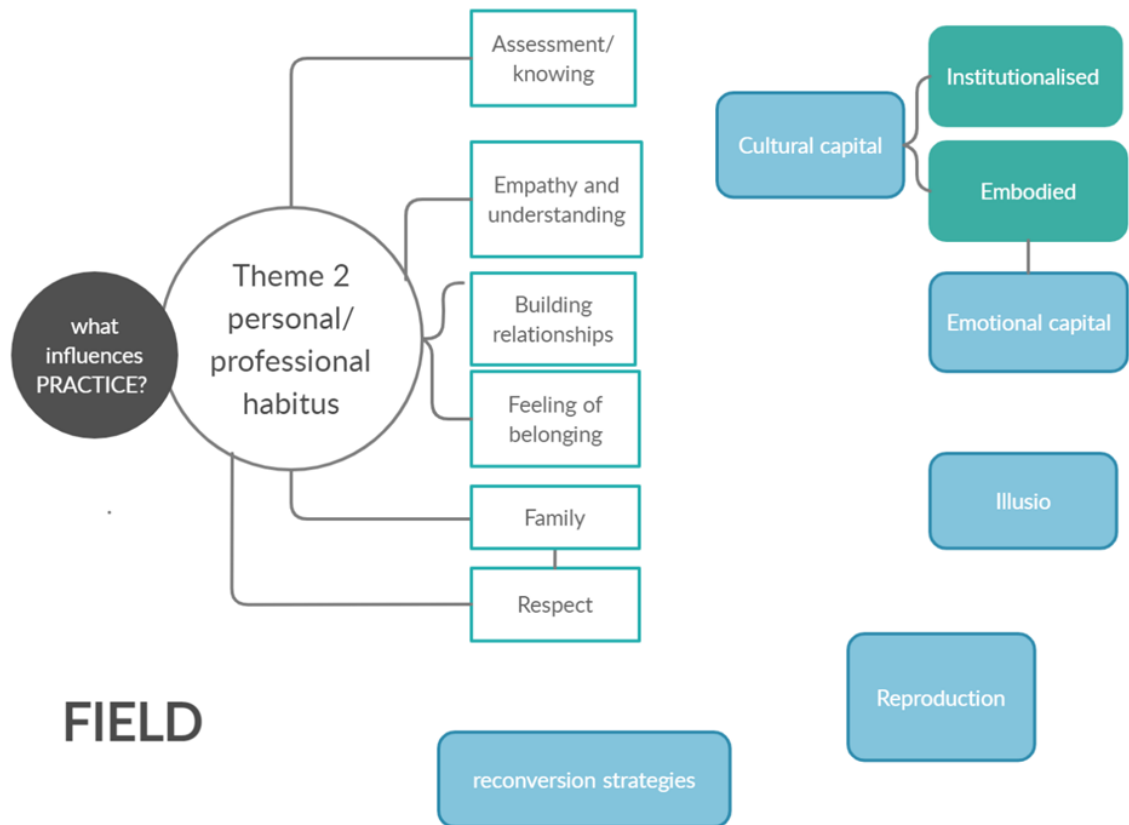
The following chapter presents data which show how the ORN as an HCA uses personal and professional habitus within their field of practice, which evoke different types of capital/power to improve their position in the field of ARC.

## Chapter Six - Personal and Professional Habitus

This chapter presents theme two: personal and professional habitus. As the ORNs in this study moved into a new field to work as HCAs in ARC in New Zealand, they brought their personal habitus developed from childhood, their culture and background from their home country. They also have a professional habitus developed from their education and experience being nurses. According to Bourdieu's Theory of Practice, (Figure 1) habitus influences practice and this chapter supports the concept that the practice of an ORN working as an HCA in ARC is influenced by both their personal and professional habitus. The theme was developed from codes that were grouped to develop sub-themes. Part of personal and professional habitus sub-themes: respect for older people, feels like family, building relationships and feeling of belonging are presented with an interpretation using a Bourdieu lens, reconversion strategies, reproduction and illusio, are revealed (Figure 13). Sub-themes, namely empathy and understanding, and assessment/knowing are also presented, which demonstrate the influence of a professional habitus where embodied cultural capital gained from nurse education and experience, is used in the role as HCA in ARC in New Zealand.

Figure 13

Theme Two Personal and professional habitus



The findings from this study showed ORNs as HCAs used dispositions developed as part of personal and professional habitus that led to building relationships to help navigate the field of ARC in New Zealand. It became apparent that these relationships are essential to provide care. However, there is a shared need for social connection between residents and the ORNs as HCAs, as the latter seek a sense of belonging and a feeling of fitting in. There was a tension between personal and professional habitus, as dispositions from a personal habitus became embodied cultural capital, valuable for gaining an acceptable position and a sense of belonging in the field as an HCA. However, there were also “murky waters” as the ORNs’ practice is also influenced by a professional habitus and the associated institutionalised and embodied cultural capital that differentiates the ORN as HCA from other HCAs.

## Respect for older people

Respect for older people had been taught and expected in Indian and Filipino culture, therefore is part of habitus they bring with them. This appears to be translated into the way the ORNs as HCAs care for older residents, signifying the respect that influences their practice. All participants spoke about respecting older people, some admitting to caring for the residents as if they are family members, perhaps meaning they show them the same respect. Respect for older people in India and the Philippines is demonstrated by acts such as standing up if an older person enters the room, taking their hand to the forehead, obeying them, appreciating their wisdom and seeking advice. Living arrangements which include three or four generations in the family home and providing care as they become less able to complete activities of daily living independently, had been part of these participants' everyday lives and were signs of respect.

Aswathy spoke about respect for older people that she was taught as part of her culture. She said:

*Like we are told to respect the elders, so in our culture it's like our grandma or father comes to us, when we are sitting we are told to stand, when we see him we will automatically stand, and we do, I don't know what to say, we will like touch their foot and do like this [demonstrates touching of the feet], if they are too old.*

Touching the feet is a way of taking “blessings” from an older person in Indian culture, recognising their age, wisdom, and knowledge.

Aswathy continued saying when she showed respect to the residents, she felt she was “allowed” to care for them, suggesting the resident is accepting of the care that Aswathy can provide. She said:

*I was taught that I have to respect the elder so, so that's a thing, I will respect the elders so whatever they show to me I have to respect them, because they are elders.....many of them [the residents] like they will be hesitant to ask, like for our care, so when we start showing them respect, and when we start showing them the*

*care, they will automatically that starts allowing us, and they will let us do all the cares.*

Manu also explained how respect for older people that she was taught in her culture has helped her care for residents in ARC in New Zealand. Manu explained *“In our culture it's very important to respect old age people, we always respect them, so I think that the respect and the love, that helped me”*. Rose believed the same as Manu, saying *“In my culture also we always respect the elderly ones, then we usually give special attention to them, we also greet them whenever we saw them.”*

Researcher *“Can you tell me what you mean about giving them special attention?”* Manu answered:

*We always stood up when we see the elderly one, we'll greet them, and we can what else? We need to engage them, we need to talk to them, we will be asking about their home, their children so they will just, changing [distracting] their mind. Respect taught in my own culture helped me working over here.*

Rose also explained the living arrangements for a typical family in India when she said:

*In India, all the elderly, everybody lives together as a big family, even though they are having any disease condition like dementia or Alzheimer's, they live with their son or daughter, and for any disease condition they will be going to the private hospital or the government hospital.*

Manu explains her understanding of her culture and why older people are cared for by their family in India. She said, *“we think that our parents look after us, and that's why we have to look after them, so most of the parents, the daughter or son, the children are looking after them”*.

Bourdieu (1977) referred to behaviours developed at a young age, similar to those described by participants that show respect for older people, as “sets of rules” established in the family. These “rules” come with “a sense of honour” embedded in childhood as mental dispositions, consistently expected and practiced, they become a permanent part

of habitus. Older people in New Zealand like those in India and the Philippines want to be respected and therefore unknowingly “set the rules”. Consequently, the residents determine some of the cultural capital of value in the field and influence social power. Participants felt showing respect “helped them” and “allowed them” to provide care, indicating a hidden strategy to use embodied cultural capital (showing respect) to develop relationships and acquire “a feel for the game” in ARC.

### **Feels like family**

Respect for the residents in ARC is not demonstrated by the ORNs as HCAs using learnt customary rituals, such as touching the feet but the respect is transformed into acts of kindness, listening and caring for residents as if they are family.

July believed her culture to be responsible for her kindness, she says:

*from my culture, there is, you know, everything I think from our mind. We have some humanity, it's from our mind. Umm, we know at times we will think like that, suppose if I were in that position – what will be that situation that is what I am thinking.*

Shay explained how caring for residents is like caring for her grandmother. Shay said:

*I think the culture of taking care of the elderly in your family is ... before I came here to NZ, I was taking care of my grandma as well. So, we set up a hospital setting in our own living room because that is where she wanted to sleep, so you set up a hospital thing. We have an oxygen tank, we have a commode – it is like a hospital, like a ward actually. So, taking care of the elderly I think is what influences mostly the Filipinos in working in aged care because we kind of know how. It is our culture already that we need to take care of the elderly in our family.*

Shez also cared for her grandparents, and she cared for the residents in the same way as if they were family. Shez said:

*I practised taking care of older people with my grandmother, and my grandfather so, it's just like, when I take care of my residents, I just consider them as like my*

*own family, like how would I feel if, if my grandmother was taken care of by another person, so I would treat this person like how I wanted my grandmother to be well taken care of, so just that.*

Deep explained how the residents feel like family and how this feeling benefits her in the role of HCA as well as providing her a connection she misses with her family.

*It's nice experience, like you can talk with them, and they will share their life experience with you, sometimes they are really emotional, and I also get emotional that time because I'm far from my family, so yeah it's a nice experience, and you can feel like you are with your grandfather, grandmother, yeah it's nice experience.....it feels like family, you love to go to work, if you are home alone, you can talk with them.*

Shez added “it’s a bad feeling when a resident dies it’s like one of your family has gone” and “we are caring at home [for older people in the family] maybe that helps us to care here too”.

July explained how she also treats the residents like her grandparents, she said:

*you don't yell on them, they're like our grandparents, they don't know what they are doing.....They are like our grandparents, they sometimes used to do that thing with us [provide care], you know as you're getting older, that's the natural things you know like as the person grow old they become a baby, they demand like a baby, maybe they don't feel hungry, we can't force them to eat, you can't push food in their mouth if they don't want to take it in, so patience is really important.*

July also explained how she felt needed by the residents, saying

*Like in here you don't, you don't have any right to do anything [nursing procedures], you just have to take care of them. It is also a great thing to do for any person who need us, it's also a part of nursing to take care of a person,.... but I like to work here because you know they need us, that's why*

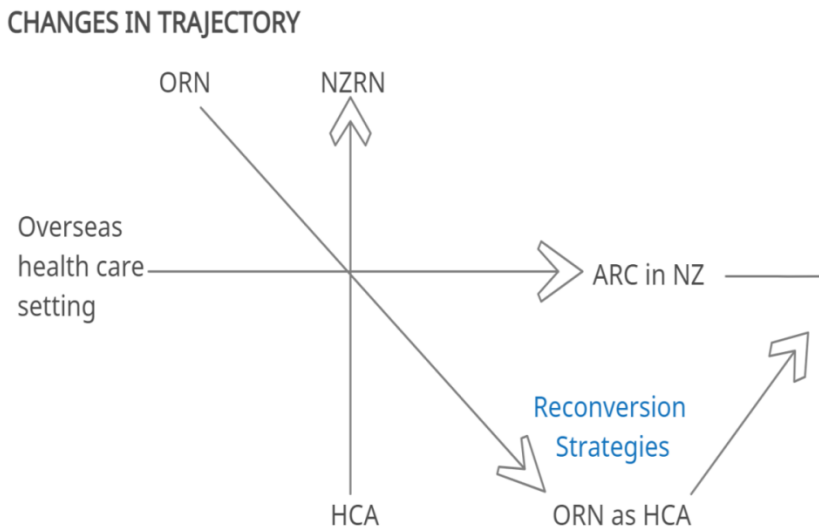
Junu explained how the residents often know the staff better than their own family, Junu, like July felt needed by the residents, giving the ORNs a sense of belonging. Junu said:

*the old residents, I mean especially in dementia, they're all familiar with us, and sometimes we did feel that they are our family members, because we always we're talking them, and we're giving them food, and if they want to go to the toilet, we're toileting them and they feel so, sometimes their family will come and talk to them, they don't want to talk to them, they want to talk to us.*

Showing respect and treating residents like family, demonstrates that the “sets of rules” which are structured practice, are converted and implemented in alternative ways as an individual is free to practice (Bourdieu, 1977). The ORNs as HCAs incorporate objective structures from personal habitus into second nature practices in the new social space of ARC in New Zealand. Bourdieu believed that structures are reinforced or modified as individuals adjust practices based on past experiences, according to the present situation (Bourdieu, 1990; Bourdieu & Wacquant, 1992). The interplay between structure, power and agency is where practice happens, the objective structure of showing respect gives the ORNs as HCAs embodied cultural capital (power) to practice freely (agency) when caring for residents. Bourdieu refers to this as reconversion strategies, which serve to improve a person’s position in a social space (Bourdieu, 1984). A field is structured to allow vertical or horizontal movements in position. Vertical movements will often be upward in the same field (Figure 3). When the ORN moves to an HCA role in ARC, there is a transverse movement (from one field to another) and a downward trajectory. Over time the ORN as an HCA changes the direction of the trajectory using reconversion strategies to convert one type of capital to another (Figure 14).

Figure 14

### Changes in Trajectory



Reconversion strategies (p. 38) are used unconsciously in everyday practice to navigate the social field (Bourdieu, 1977). The ORN as an HCA has a personal and professional habitus that has developed an intuition for “rules of the game.” This intuition helps them navigate the transverse and downward trajectory. Showing respect and treating residents like family was part of building relationships, which is crucial to working within the social space, and for the ORNs as HCAs to feel connected and to feel a sense of belonging in the new field. There is however a tension between personal and professional habitus, as the ORNs as HCAs used traits from a personal habitus to build relationships there is a chance there is a violation of the therapeutic relationship in which boundaries could be crossed. In this case the relationship is not only fulfilling the needs of the residents but also the personal needs of the ORNs as HCAs as they miss their own family members and want to feel needed and gain a sense of belonging.

### **Building Relationships**

Building therapeutic relationships with residents is an integral part of providing care for residents. Some participants found connections through common interests, while others felt that building relationships was not a problem because of their experience as a nurse. A therapeutic relationship is one which centres on meeting the needs of the resident and

not the needs of those providing care (Nursing Council of New Zealand, 2012b). The relationships formed between participants and the residents they cared for were beneficial both personally and professionally for ORNs working as HCAs.

Manu recognised the need to build effective relationships with residents and felt it important to spend time with them and listen to their stories. Manu also benefitted from these interactions sharing her stories and learning about the resident's culture. Manu explained:

*It's good to hear their stories and spend time with them, and I feel it's very good, and even I share when I tell my, especially when I tell about my marriage and all those things, they are very surprised and they really like to hear, and I think it is nice to hear the cultural difference, and sharing all the things and not just staying with them.*

Deep described how she found a connection with the residents saying, *"I love the old songs and the residents love the old songs, this is something we have in common"*. Deep explained further as she recognised she had more in common with the residents than just the old songs. *"I am feeling with them, they are feeling the same, I am feeling like that, alone without any family so they are going to feel the same"* she said.

The connection benefitted Deep and the residents as both were away from family, indicating there is a mutual interest in the relationship. For Deep, building a relationship with residents was required to fulfil the role of an HCA to provide care but Deep also appreciated how important this social connection was for her personally.

Without realising it, Deep and Manu were accruing social capital which Bourdieu described as capital that is acquired through connections in a group, the first such group for most people being a family (Bourdieu, 1986b). Deep acknowledged she misses the connection with her family. In this situation there is a potential for boundaries in the therapeutic relationship to be blurred causing a tension between personal and professional habitus. As an ORN, Deep likely knows about professional boundaries. Still, as

she is no longer working as a professional (an RN), she may not be concerned about maintaining professionalism if there is a benefit in the close relationship with the resident.

Aswathy told of a special relationship she had with residents, which showed how her ability to build relationships enabled her to practice her role as an HCA. Aswathy explained *“I don't know why she was really happy with me, and my RN clearly used to tell me always that she likes you, and she always want me to take care of her”*.

Researcher – “So what do you think made that connection with that particular resident so special?” Aswathy replied:

*Maybe the way that I care them, like she wants to have shower sharp 7am, so my shift starts at 7am but because my husband also works in the morning, so he drove me at 6:45am, so I go 15 minutes early and get the handover, and reach her room at 7am. Give her shower and dress her, and bring her to the dining room, and the second one he needs to shower at 7:30am, I will be there at 7:30am, so maybe because of that, like I have never changed the time for the 1 year I will be there, when I'm working with them I'll be there at 7am and 7:30am with both the residents so, maybe because of that and like both of them like talk to me about their families, and they ask me about mine, so we used to talk a lot maybe because of that we had a good connection.*

Aswathy made a special effort to go to the resident's room early although she could have waited until her shift officially started at 7am. But Aswathy saw the investment of her own time as worth the effort, gaining satisfaction from pleasing the resident, without realising she is acting strategically. There is an “illusio” formed as Aswathy believes “the game is worth playing”. Bourdieu explained illusio as being invested or having an interest in success within the field (Bourdieu, 1998). Aswathy's actions are interest-oriented and showed not only is the game worth playing but she knows how to play it, perhaps due to her past experience of being a nurse.

Rose also demonstrated she knew how to build effective relationships with residents when she acknowledged the importance of including family where possible. Rose said:

*I would have a good talk with family members .....they told me about the food, that they have more like to have, and also at the time of the bed, where should keep the pillows, there was one patient who liked to keep the pillows, between her hand and legs, and one in the head, and also one in the back, might make her more comfortable. Like food some person, some of the patient like chilli sauce, one, always he need chilli sauce with any food, even the bread toast, the sandwich everything always he need chilli sauce. If we give chilli sauce he will be having his food.*

Mike believed he could build relationships easily because of his experience as a nurse, which meant he was using cultural capital developed during his nursing career in his practice as an HCA. Mike said:

*I think working as a nurse is an advantage, if you're working personally with other people, because you tend to deal with other sorts of people already, so it's not really a problem dealing with other people, it's an advantage if you're a nurse, because you're used to dealing with heaps of people, so the relationship, building a rapport is for me it's not really a challenge.*

Building relationships and having connections with the residents in this new social space appeared significant for the ORNs as HCAs. As a nurse, they may see treating residents with respect and like family, as a way of building relationships and gaining trust. There may be a sense of family loss as the ORNs are living away from home, therefore treating the residents with respect, like family, may give the ORNs a sense of belonging. Family is important, a natural social group where there is a need to belong, be loved, be cared for and care for, and protect others. Spending time together, sharing moments, building memories, and having connections are all part of belonging to a family. This need to belong or the need to be needed is strong when living away from one's own family and maybe greater in people who decide to become nurses. For them, the caring extends further than their own family.

July gets job satisfaction because she felt needed which made her feel valued and gave her a sense of belonging. July said, *"I feel awkward for, that you can't use your skills... but I like to work here because you know they need us, that's why"*.

Another participant, Junu felt happy that the resident chose to be with her over her own family most probably due the dementia and not remembering her family. Junu took some satisfaction from this as she explained:

*we feel really happy because they're knowing us, and they're considering us like a family member, so that was a really good experience.....I said Ms X come here, and she come with me but that moment I felt really happy, you know as I told you before, because they won't realise [recognise] their daughter or their family, who always cared them*

Junu appeared to be the important one during this interaction which made her feel valued and needed, like July she had now found a sense of belonging. However, again this is an example of tension between personal and professional habitus as there is a personal gain for Junu in the relationship.

Deep described how she appreciated being valued when she said *"it's nice when someone says ok, you are nice, you are good - resident is appreciating you it's like an award"*.

Mike explained how he had made a friend and had become attached to a resident saying *"I actually have a friend, I consider him a friend, you know how you get attached with other clients, because he treats me as a brother already something like that"*

The residents in ARC perhaps replace the participants' family members at some level. HCAs provide care, care for, and are caring every day for the residents. They listen to their stories, their woes, their complaints, and their happy times. HCAs spend time with the residents, probably more time than anyone else, either staff or family members.

Connections are made, sometimes not easily, but these connections become long term often ending when the resident passes away, and a feeling for the HCA like a family member has died. A sense of belonging comes once connections have been made, and the

ORNs as HCAs feel valued by the residents. A sense of belonging is a natural human social need and is acquired by caring and being cared for emotionally in a social group. The resident might look forward to a particular HCA coming on duty or ask to be cared for by a particular HCA because they like the way they care for them. The resident will enjoy telling their stories and being listened to by the HCA. The time the HCA gives is precious for the resident in the absence of family members and the HCA will benefit from this too. So, for some, there is a mutual bond, when both residents and HCA have been separated from their own families. They replace what they have lost with each other, creating the family feeling and the sense of belonging. It is apparent that these relationships are essential to providing care. However, there is a shared need for social connection between residents and the ORNs as HCAs, as the latter seeks a sense of belonging and a feeling of fitting in. For the ORNs as HCAs, there is a tension between personal and professional habitus, but this appears to be part of the route to being accepted and “fitting in”.

### **Empathy and Understanding**

The role of an HCA in ARC is looking after residents, to tend to their needs, both physically and emotionally. Empathy is an interpersonal skill and involves being able to comprehend others’ emotions and the first stage in the desire to help someone (Reynolds, 2017).

Understanding is related to having some knowledge about a situation or a feeling, enabling a person to comprehend more completely (Reynolds, 2017). Showing empathy and understanding is part of a set of competencies classed as emotional capital used in a caregiving role (Cottingham, 2016). Bourdieu does not write about “emotional capital” per se but these types of “soft skills” or dispositions developed in childhood, become part of personal habitus. Emotional capital is cultural capital; valued in the caring role it becomes integral within the professional habitus of a nurse (Reynolds, 2017). The following data represent how ORNs as HCAs use emotional capital by demonstrating empathy and understanding for the residents while providing the care they need.

Manu showed she understood the residents' needs by spending time with them. She said, *“It's good to hear their stories and spend time with them, and I feel it's very good”*.

And Aswathy showed empathy by recognising that the resident would gain comfort from communication with her after a fall, she said *“I just keep talking to her”*. Aswathy also showed understanding of the situation, she added:

*Yeah if me or another HCA was with her, we should have prevented that fall, yeah she was walking alone because, if I was with her I can like watch her closely, if she was about to fall, I can try to, try not hurt, like not to fall on the floor.*

Mike demonstrated empathy and understanding by providing tender loving care as if the resident is a family member. He said:

*It helps working as a nurse, because usually when I'm working I tend to think that every client is my relative, or loved ones so, tender loving care you know, working as a nurse you tend to give it to every client that you have, and I tend to apply it even during working as an HCA.*

Mike's statement infers that he believed he provided tender, loving care because he is a nurse. Still, it could be that this disposition was developed as part of personal habitus and may have been a reason for taking up nursing as a profession. When working as an HCA, Mike does not need to change practice concerning empathy and understanding; he continues to do so as it is part of his habitus.

Jose expressed her passion, demonstrating empathy and understanding by being gentle and helping the residents have a good quality of life. Jose commented:

*I do it with a, it's my passion to care for this person, like behaving very gently to them, making them as comfortable as possible, we do as much as we can to make them feel happy and have a good life.*

Junu believed a “caring mentality” or showing empathy and understanding is part of being a nurse. Junu said *“As a nurse we've got a caring mentality, if there is a patient or a resident we're caring them, there is no difference, same as back in India”*

This quote from Deep shows how she expressed empathy and understanding making connections through music and how she shared the sadness of a resident:

*I love to listen to music, and in dementia care unit they have the music system as well, so yeah I used to play a lot, and I love the old songs, and all residents also love the old songs, yeah so that thing is common for us, and sometimes I ask from the resident they sing, and it's really nice to hear from them, because some residents sing really nicely, and they know the lyrics if the music is going on, they know the lyrics, and sometimes they cry too, maybe because of their memory, they are missing home. I had like really sad moments with them, like if they are watching one of our residents, she's from UK I think, there was a program about the UK houses, in the TV they always show the houses, I think houses and housing something like that, and she was watching that TV, and after watching that she started to cry, and I went to her, close to her and I ask what happened, she said I'm just missing my family, I had home there, the same type of home, and she like, she again realising that memory came in her mind, she all like thinking about that thing, and that makes her cry, and she cried really badly that time, so that moment is really sad, because I can't see a person, if somebody is crying, yeah it makes me also cry.*

Throughout historical phases of social construction the concept of caring has constituted values that stimulate emotions, through structures such as family and religion (Gonzalez & del Carmen Solano Ruiz, 2011). From a Bourdieu perspective mental structures are imposed and introduced in the minds and bodies of people (Bourdieu, 1998). A caring mentality (being kind, showing empathy and understanding) which is emotional capital, is a product of a mental structure may come from the social construct of “family”, which is both a structuring structure (an objective category) and a structured structure (a subjective category) (Bourdieu, 1998). The words of Bourdieu and Passeron (1977, p. 203) are used to clarify this further:

Objective structures (eg. family) tend to produce structured subjective dispositions (mental structures such as a caring mentality) that produce structured actions (empathy and understanding), which in turn tend to reproduce objective structure.

The habitus acquired in the family at a young age brings about the structuring of future experiences as habitus is transformed through restructuring (Bourdieu, 1977). The “caring mentality” revealed through showing empathy and understanding is an embodied cultural capital (emotional capital) which is shaped through life, beginning in the family but developed further during education and experience, it becomes part of the professional habitus of a nurse.

The ORN brings a professional habitus of a nurse to the role of HCA in ARC. As well as emotional capital, the ORN is able to utilise skills and knowledge (institutionalised and embodied cultural capital) in the HCA role which was accumulated whilst being educated and working as a nurse. The following section provides further data demonstrating how professional habitus influences practice of ORNs working as HCAs.

### **Assessment/Knowing**

As well as providing physical and emotional care, caring for someone is also noticing changes, knowing when things are different and being inquisitive of the change. The ORN comes to the role of an HCA with an accumulation of nursing knowledge, including assessment and critical thinking skills, and they know the consequences of not noticing residents’ changes. These skills are described by the participants as they are regularly used in their daily work as an HCA.

Junu described how she assessed the residents while providing personal hygiene care.

Junu stated:

*Even we care, even we washing them we always check their whole body, is there any, any bruises, any sort of redness anywhere, so is there any redness in their hip or anything, that's the time of starting their pressure area, so we have to be careful with that, so while we're caring we're assessing the resident top to bottom.*

Sandy also described the assessments she made while caring for residents: an HCA without the assessment skills of a nurse, may be more focused on completion of the task such as showering. Sandy explained:

*Everything which is related to our patient, like any bruise, any medical condition you find, any alteration you find in your resident, like you cared for him for long time, you easily observe like you are the only person who stay near to your residents, so you understand better like if he hasn't done any poos from a long time, these are also like if he's constipated that's also a concern, if he's not peeing, if there's any rash over there, if they have any redness or anything, because they can't tell you anything by them self, so these are I think the typical things you have to observe, and tell to the RN.*

Shay explained how providing direct care with the residents gave opportunity to complete assessments in a holistic way, she described her assessment as a nurse would describe it – as holistic, meaning it considers all the dimensions such as physical, social, mental and spiritual wellbeing. Shay said, *“health care assistants have a lot of assessment skills to do because they are more hands-on with the residents; they know the residents very well, from head down to toes.”*

Shay added:

*When you (an ORN) are a Healthcare Assistant you are assessing almost all because you are hands on with the resident from the appetite, from the mental state, from their mobility and from their numbers of hours of sleep. You assess them. If they are able to communicate well with other residents – so that is pretty much it. It's like holistic care actually.*

Aswathy spoke about recognising signs and symptoms of a stroke which she felt she would not be able to do if she were not a nurse previously. Aswathy said, *“when she start speaking I noticed that her speech is slurred, and eventually her lip started drooping to one side, and she just fall like this.....”* Aswathy demonstrated the resident’s position

when she fell. Aswathy added *“maybe because I know what a stroke is, if I was not a nurse, I may not be able to recognise she was having a stroke.”*

When caring for a diabetic patient Deep recognised signs and symptoms of a low blood glucose and explained:

*I know this is a serious condition so I can tell her, and explain her what's the thinking, and I find out if that person is not nursing background, and just a health care assistant, they don't know, and sometimes it makes really serious condition, and that's not their fault because they don't know this type of condition, what can be happen.*

Rose also recognised signs and symptoms of low blood glucose and she knew action was required stating:

*Yes because sometimes if the patient get agitated or anything, I used to ask the RN to check his BP, or sometimes I feel, one of the resident become so pale and not at all eating anything, just starting to sit, always sitting and then when I ask them to take the GRBS [blood glucose level] , the sugar, it was too low, it was too low then really that RN appreciated me because, because we have some knowledge, we just ask the registered nurse to come with the GRBS strip. I think something had, help me it really helped me to do, to work as HCA because of my nursing knowledge in India.*

ORNs know when things are not right; they cannot stop knowing because they are no longer working in the role of an RN. The role of an HCA is to care and the HCA, who is an ORN, might care differently because of their professional habitus.

ORNs as HCAs complete assessments and interpret the data to make decisions. By identifying what is normal and what is abnormal, Manu described how she started to interpret what she noticed. Manu explained:

*the way we see the residents it's different, it's not like we see like common people, if the common people works with resident it will be different I think, because then*

*we work in India, we usually like see the conditions, we can identify what is normal and what is abnormal, but I don't think so if I'm not a nurse back in India I won't be able to identify what went wrong with the residents, especially when I change like for example if I change a diaper or something, I can see what is the normal skin colours and what will be the abnormal one, and what I should do immediately.*

Manu added:

*I feel very like proud because, knowing that which is abnormal and able to identify which is not normal, and able to take the exact step how to do it, I think it's very good, I feel proud about that.*

This showed how Manu was able to use her skill and knowledge which included assessment and clinical reasoning skills from her nursing background, in the role of HCA. The feeling of pride would give Manu a sense of satisfaction, a sense of value and ability to contribute in the field.

July has also acted on assessment data, she explained:

*I have seen that it was completely watery (a resident's bowel motion), I think that was few times it's happened. Two times I was with him. And I observed that his skin discolouration, and his eyes, so I informed the RN at the same time, and then, I think he is going to collapse, and had him in the proper position in the bed, semi fowlers position, and I knew he already has COPD.*

Shay also completed assessment and showed appropriate action, Shay said:

*Yes there was this time when, there was these 3 consecutive days that I was handling the resident, I was with this resident, on the second day he was starting to get confused and started to you know wander, and on the third day, he got this, ah the confusion really was, how do I say that, the confusion becomes worse, so I said ok probably he has this infection, so I said maybe can we do like a dipstick, or yeah so just tested and yeah he got this infection, we found out that he got the infection and started, started to have fever, so he got the, and also we found out*

*that, the catheter, something is wrong with the catheter that although the usual days he has, the output was adequate, but during those time we were wondering why the output was not good, and so we checked, that's why we referred ok so probably something is wrong with the catheter, so I just informed you know things like that, that you observe with our residents, we just refer to the RNs.*

Shay also explained an assessment she undertook and how it felt like she is still working as a nurse.

*there was one resident that had a fall and it was not just a regular fall because she was in so much pain, she was in so much pain on that day in her hips and she had a history of hip replacement.*

*What I did was that I just did the obs (temperature, pulse, oxygen saturation and blood pressure), I took the blood sugar level and assessing the mental state – if she feels like she wants to vomit or dizziness or headache, yeah. And assess any physical injuries ... any physical injuries and any dislocations that are present.*

*.... it kind of feels like you are still working as a nurse*

Shez believed her nursing background is crucial to the role she undertakes as an HCA. Shez said, *“maybe the background of nursing is one of my, one of the backbone of my work right now, and my experience, my experience of being a nurse, of being a bedside nurse”*.

Mike believed there is a difference when an HCA has a nursing background. He said, *“because as a nurse, I'm working for a nurse for more than 10 years, it's already in your instinct that you do these things [Nursing procedures]”*.

When asked “how did you manage this?” his response, demonstrated a professional understanding of his position. He said, *“they give you a list of the rules, or the obligations or the responsibilities that you need to do in a rest home”*. Mike also added *“Keeping integrity that you will not do anything that would ruin your career here, so keep that in mind all the time”*

The knowledge ORNs have, cannot be forgotten or ignored. The data presented, demonstrates how ORNs use their nursing knowledge to assess and make decisions about residents. This data represents the practice of HCAs who are ORNs is influenced by a professional habitus; their practice is different to an HCA that is not an ORN.

## **Conclusion**

The respect the ORNs have for older people, combined with the loss of family connection and the need to care and be cared for, appears to influence their practice as an HCA. The way they care is different because of their nursing knowledge and background. The ORN stops being a nurse in the sense that they are no longer employed to fulfil the role of the registered nurse. However, they continue to nurse, which means to take care of someone or help someone that is sick. In the role of an HCA the ORN continues to fulfil some aspects of the role of an RN using knowledge and experience from being a nurse. The way they do this, is influenced by their personal and professional habitus, their culture, and respect for the older generation, which enables them to appreciate and see worth in older people. There is a feeling of passion for how they work: they want to do a good job and get pride and job satisfaction out of their work and the relationship they have with residents. Using reconversion strategies, the ORN as an HCA, personally benefits from their relationships with residents, as these provide social and cultural capital to improve their position in the field.

The practice of an ORN working as an HCA in ARC is influenced by personal and professional habitus, as Bourdieu (1977, p.79) states,

"In each of us, in varying proportions, there is part of yesterday's man who inevitably predominates in us, since the present amounts to little compared with the long past in the course of which we were formed and from which we result".

Previous work as a nurse has shaped the habitus of the ORN, and current practice working as an HCA will shape the habitus of the future. The tensions between personal and professional habitus in the ARC field appear beneficial for residents and the ORN

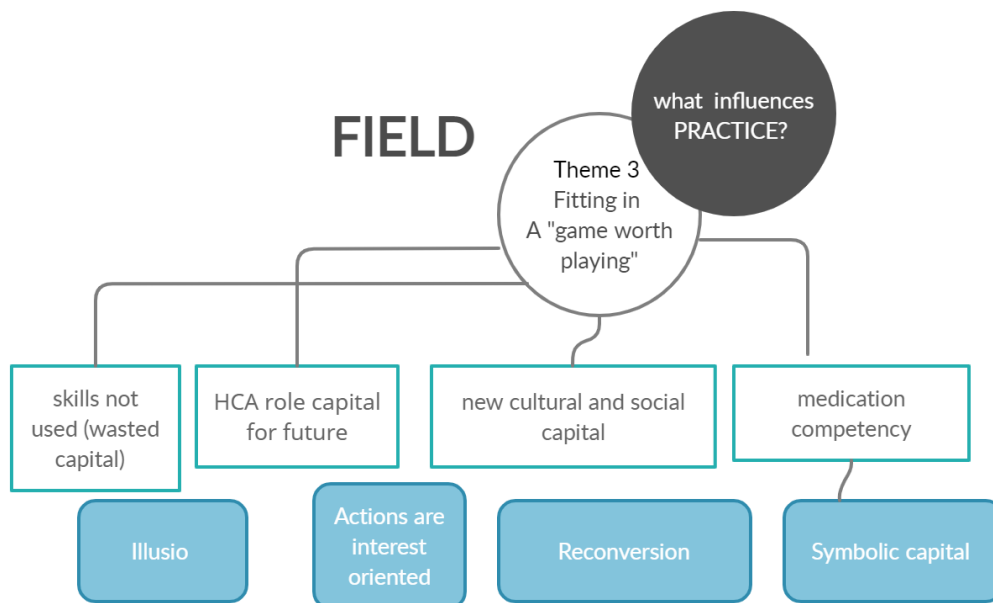
navigating the field and learning how to be an HCA in New Zealand. However, this tension could lead to erosion of their professional habitus.

## Chapter Seven - A Game Worth Playing

**Theme three** - “a game worth playing” considers the capital configuration, as the trajectory of the ORN working as an HCA in ARC in New Zealand is considered (Figure 15). Part of moving to a new field is giving up cultural capital that is no longer valued and acquiring new cultural, social and symbolic capital, to improve position in the different field. Improving position includes becoming a more senior HCA, feeling more valued and more like a nurse again.

Figure 15

Theme Three A game worth playing



Sub-themes drawn from the coding and grouped together to develop this theme were the skills not used (wasted capital), such as administering intramuscular injections and passing urinary catheters. Also the new social and cultural capital the ORNs accumulated in the role of an HCA, and how changes in capital are seen as “worth it” (Illusio), for their future role as an RN in New Zealand. Finding a sense of one’s place and belongingness appears to be part of the trajectory before the ORN feels like they “fit in”. In some ways they might never feel totally comfortable but come to a point of tolerance and acceptance of the differences in practice for them and the way things are. The ORNs unknowingly used

interest-oriented reconversion strategies to improve position in the new field. One of these strategies was completion of the medication competency, for not only did this give them more perceived seniority (symbolic capital), it appeared to give them the social gravity that made them feel valued and more like nurses again. Harker et al. (1990, p.19) explain this as the primary principles of playing the game stating “Strategy and struggle work within the logic of practice for the purposes of recognition, legitimation, capital and access to capital within the symbolic and material world.”

### **Skills not used (wasted capital)**

The struggle already mentioned in Chapter Five, includes the ORNs not being able to use some of the capital (procedural skills) that they have acquired in their nurse education and practice. Many of the participants spoke of skills they could no longer use, such as assisting with intubation and inserting an intravenous cannula. However, there are many skills, such as intramuscular injections and passing urinary catheters that are required in ARC in New Zealand. They are performed by RNs not HCAs, but not using the skills the ORNs have, appears to be wasted capital.

Sandy explained how she cannot use some procedural skills in her role as an HCA, for example, administration of intramuscular injections appeared significant for her, and it is a skill that she felt could be used in ARC and therefore it was a “waste” of her skills. Sandy said:

*Back in India we used to do everything, like we can give injections, we can admit patient, we make like referrals, we do all and every procedure like in India, there is no any particular nurse to do that particular stuff, like we are taught everything, even bed making, taking vitals, doing injections and all the things like dressings, wound care everything we have to do, not any particular nurses like in here we have to do competency for each and every thing, but in India we don't need to do that, you are able to do that stuff by your own.*

*I learn how to put IV lines over there [in India] .... one thing I learned over there [in India] that I never done before in my class, that's the giving intramuscular injection*

*and intramuscular injection I don't know how to give that but I learned over there from my Dr, he told me then I started doing that.*

Mike, who has over 10 years' experience working as a nurse overseas, spoke about the skills he has in administration of injections as well as many other skills he was not using in the HCA role. Mike said:

*NGT [Nasogastric tube] insertions, catheter insertions, giving medications like that needs to be administered, intravenously or intramuscularly, er what else, other things like the ventilator settings of course, like suctioning and all those things that are, we are allowed to do as a nurse.*

Junu also commented *"Yeah there [in India] we will do everything, each and everything, blood extraction, IV [Intravenous] cannulation, nasogastric tube, catheter insertion and yeah, everything."*

In discussion with the ORNs, they appear to bring many nursing procedural skills to the role of HCA in ARC, but many of these skills are not required in this new setting. However, they bring many nursing procedural skills required but, in most circumstances, they can only be performed by a New Zealand Registered Nurse. These skills, including insertion of nasogastric tubes, insertion of a female urinary catheter, administration of intramuscular injections, and blood glucose monitoring, are "wasted capital". Whilst the field (ARC) requires the capital (nursing knowledge and skills of the procedures), the field is governed by structural processes that do not use all the capital the ORNs bring to practice. As previously stated, the HCA role is unregulated and governed by a job description. An RN is responsible for ensuring an HCA is educated and competent to complete any delegated task (Nursing Council of New Zealand, 2012a) and currently, there is no opportunity or process for the ORNs working as HCAs in ARC to demonstrate competency in these skills as it is outside the HCA role. The ORN, prepared to "waste" capital when they accept the role of HCA, shows investment in the game, and believes that it is worth it as the field pulls them in a trajectory to be an HCA, although this may go misrecognised by those in the field. Bourdieu and Wacquant (1992, p. 98) state "Players agree, by the mere fact of

playing, and not by way of a “contract”, that the game is worth playing, that it is “worth the candle”, and this collusion is the very basis of their competition.”

Bourdieu’s concept of *illusio* is observed as the ORN being driven to succeed believes that the struggles working as an HCA including “wasting capital” are worth it as they try to “fit in” and invest towards the goal of becoming an RN in New Zealand (Bourdieu & Wacquant, 1992).

### **New social and cultural capital**

While the role of HCA in ARC does not allow the ORN to perform many of the procedural skills they have learnt in their country of origin, the role offers the ability to accumulate new social and cultural capital evidenced by all the participants speaking of new knowledge and skills they have gained. Significant new capital gained was communication in English and knowledge of the Māori culture.

Deep expressed her concern when she first arrived in New Zealand. She said:

*I will share my first experience at airport, so I booked the shuttle, and that person was I think a kiwi person, and he speaks really fast, so I couldn't understand even a word what he's talking about, that time I felt like if I can't understand him, then how can I do my study here, .....that person gave me a fright, he was talking so fast, like he's talking about something and I was like, what are you talking about sorry I couldn't understand, he said yeah because we are talking very fast.”*

Junu also found communication a challenge and explained how her English improved quite quickly by listening and talking to residents. Junu said, *“Communication that was the main challenge, communication. I could understand but not fully, yeah sometimes feel difficult.....sometimes I feel if I speak, they will not understand my English, but after one month it changed everything.”*

When asked by the researcher, *“So what happened in that month that made it change?”* Junu replied:

*While we're talking I always listen what others will say, and how they talk, and I always listen, yeah from that way I learnt much, while we're talking when I started in dementia, in other unit I won't get that much time to talk to the residents, but in dementia I always grab everyone together, and we give a group discussion or we'll talk to all the residents, and they will give their past history, and they will tell the stories, it was a really nice experience for me to improve my English as well.....  
In dementia unit we have to do the activities as well, so part of the activity we have to read the newspaper and have to talk to them, and after morning tea time we'll start reading newspaper, and start talking to them, that will make yeah big difference.*

Sandy showed appreciation for the opportunity to practice her English and recognised this would help her in the future. Sandy said:

*I learn from back in India when I did my IELTS exam, because in India you won't get opportunity to speak English, because you can't speak English with your parents, or like in here we are living, we are going to care the resident, and we have to speak English, that enhance your skills, which will be helpful for your like future.*

When asked about the challenges of working as an HCA, Rose spoke about understanding the New Zealand accent. She said *“First one is the accent, kiwi accent. Though as you know English is our second language, so I studied in English but the accent might be different, so I feel a bit difficult with both the patient and their families...”*

Some participants found communicating in English a challenge initially, particularly the accent and New Zealand colloquialisms. Building social and cultural capital by practising and learning English language was significant for all participants. Social capital, because it allows the ORN to build relationships with residents and staff, which means they are more able to contribute and it is therefore part of the trajectory for the ORN to feel like they are “fitting in”. Embodied cultural capital is clearly important, because the language becomes more natural over time and this means the ORN is more likely to succeed in the workplace and New Zealand society as a whole. Bourdieu (1992) refers to this as linguistic capital

which provides the ORN symbolic power, not only whilst working as an HCA but it contributes towards meeting NCNZ requirements in English Language before becoming registered as an RN in New Zealand. There is no requirement for an IELTS [International English Language Testing System] score to become an HCA in New Zealand as a non-regulated workforce, although job descriptions may ask for good verbal and written communication skills which would be assessed as part of the recruitment process.

As well as English language, learning about the Treaty of Waitangi and Māori culture was also significant embodied cultural capital that supported building relationships with Māori residents and consequently helped the ORN to “fit in”. Rose said:

*Other one [challenge] is the culture, we live in the far north, most of, I think 80% of the patient over there is practising Māori culture, so I was not, I don't know much about the Māori culture, so after that I came to know.*

Rose said she taught herself by searching on websites, while her husband also helped her because he had been in New Zealand for eight years. Having a husband to help, gave Rose social capital which encouraged and helped her to integrate into New Zealand culture. Rose also learnt from staff in the facility.

*Staff taught the pillow<sup>7</sup> using, then they are very happy if we talk them in Māori, and also even though we don't know Māori, at least greet them in Māori, my husband always ask me to greet them in Māori, like kia ora <sup>8</sup>, even after when I get home from my shift, if I say ka kite <sup>9</sup> or po marie<sup>10</sup>, I can see a big smile [from her husband].*

Manu also learnt aspects of Māori culture saying “for example I hear like we are not supposed to touch their head.....we have to ask permission”. Junu also said “Māori culture is a bit different, and I heard that some of the culture that means if they're feeding there

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<sup>7</sup> Māori cultural practice uses the pillow as a resting place for the sacred head and is used for this purpose only.

<sup>8</sup> Kia ora is the Māori word for hello, a greeting of good health (Te Aka Māori Dictionary. (n.d.-d)

<sup>9</sup> Ka kite is a friendly, informal way to say good bye in Māori (Te Aka Māori Dictionary. (n.d.-e)

<sup>10</sup> Po marie means good evening in Māori (Te Aka Māori Dictionary. (n.d.-f)

*we won't give their food over the head". Junu also learnt that Māori prefer to care for older family members at home, the same as her own culture, stating:*

*One day I was talking to one of the resident, Māori resident, in the dementia and she was saying to me, according to their culture, they won't feel to put their mum or dad in the rest home, as long as they've got, as long as I mean how much they can care, they will care at home they won't send them to a rest home, that's what I heard from one of the Māori ladies.*

Deep was able to apply her learning from study in New Zealand to the care she provided as an HCA. Deep said:

*In different culture they like a different thing, especially like here the specific they have like Māori culture, yeah so like I came to know about tapu and noa in my study time, but here [in the Aged Care Facility] I like practically see that thing.*

Deep was asked to give an example and replied:

*like they don't like to sit on the table, which I learn in our study time, like in tapu and noa that's a sacred place, so like pillow they don't want to put under their bottom, yeah that types of things I came to know here.*

Providing evidence of understanding and application of the Treaty of Waitangi and cultural competency is part of the process of becoming an RN in New Zealand (Nursing Council of New Zealand, 2011). Therefore, the opportunity to learn and practise in a culturally safe manner is building social and embodied cultural capital for the HCA role but also for an RN role in the future.

### **Symbolic capital - Medication Competency**

Administration of medications is a task delegated to an HCA by a Registered Nurse under the NCNZ guidelines for the delegation of care by an RN to an HCA (Nursing Council of New Zealand, 2012a). Participants believed they were allowed to give medications because they worked as an RN previously.

Manu said:

*but for us like the people who worked as a nurse, they allowed us to give the medications.... they're considering us as like assistant of the nurse, where we can give the medication and help in the registered nurse role, looking after the patient.*

July also commented, *"I did my medication competency, so later I can give medications as well..... It is because I, as a registered nurse, overseas registered nurse"*

Rose expressed how pleased she was to be able administer medications, and in this situation in a dementia unit, there was no RN in the closed unit. Rose said *"I was really happy because they ask me to do the medication competency.....they give only to some of us caregivers, so they selected me as one of the caregiver, that is why I was giving the medications"*.

Jose was asked why she thought she was chosen to be a medication administrator, she replied:

*I think maybe because I had already done my Bachelors of Nursing, maybe because of that, and also I had worked as a senior caregiver over there, because I was in the dementia unit, over there they are having one senior caregiver and one junior, who is working for the 8 hour shift, in that dementia unit there is no registered nurse, the nurse should be coming from the rest home level, it is a closed unit, dementia unit is a closed unit, so maybe because of that they give me that, that thing to do.*

Jose also explained the seniority and her responsibility for giving medications in a dementia unit. Jose said, *"Even in dementia care unit, it was like two health care assistants in a shift, one senior and one junior, so I was a senior health care assistant the whole 1 year, and so I was giving medications."*

Shay explained the additional responsibility that comes with the medication competency, which demonstrates a change in (seniority) position in the field and how this made Shay feel more like a nurse again.

*At first when I started working in the aged care, it was just giving care but after I have worked for almost a year, I was given the medication competency and now it feels like I am just doing my nursing work in the Philippines and here as well. Because here, if you are given the medication competency, you are tasked to give the medication except for those injections. And of course, a nurse is not there all of the shifts, they are just there until 5. So, when something happens – if there is an accident that will happen – it is the medication staff who looks over all the things and then calls the nurse and calls the Nursing Manager as well and calls the families as well.*

Most of the participants expressed how important completing the medication competency was for them, probably because it was symbolic capital that supported a move into a more senior HCA position. Completing the competency also made the ORN feel more valued, more like a nurse again and gave them cultural capital for the future role as RN in New Zealand.

Reshaping institutionalised cultural capital used as an RN to improve position in the field as an HCA is another example of what Bourdieu referred to as reconversion strategies (Bourdieu, 1984). Reconversion strategies occur when there is a gap in a social space that can be filled by converting one type of capital into another. In this situation the gap is the need to have a person who can administer medications.

As ORNs are prepared to work as HCAs and take on more responsibility to improve position in the field, they reproduce the social order by accepting what is offered to them. For them it seems there is little choice as they are in the midst of a class struggle which is imposed on them by the broader fields of power.

The NCNZ guideline outlines the responsibility of the RN delegating a task, the employer and the HCA accepting the role of completing the task (Nursing Council of New Zealand, 2012a). NZNO (2018) provide the guideline for administration of medication which includes the responsibilities of all involved in this task including the RN, employer and HCA. The HCA whilst accepting responsibility for their actions, remain accountable to the

RN and have a responsibility to inform the RN if they feel they do not have the skills and knowledge to carry out the delegated task and to report concerns to the RN or manager. The RN needs to be satisfied the HCA to whom they are delegating has an appropriate level of training and is assessed as competent. This delegation and acceptance of responsibility requires understanding of professional and legislative issues for all parties including the HCA (NZNO, 2018). It is arguably a professional role that the HCA takes responsibility for.

### **HCA role, capital for future role as RN**

Some participants felt it was really useful to work as an HCA prior to becoming an RN in New Zealand, signifying that despite the struggles working as an HCA, it may be worth it in the long term. Junu said:

*just start as a health care assistant, it's not nursing but it's a part of nursing, so if in our mind we have to be a nurse here, it's good to work as a health care assistant before, that's what I can say that....coming from India to here as a registered nurse, they don't know how to use a hoist and manual handling or anything, but we know everything who already working as a health care assistant here.*

Aswathy felt working as an HCA helped her to understand both HCA and RN roles which would help her in a future nursing role. She said:

*Because if I came to do the CAP directly from India, I won't be like, I don't know anything about the health care system in New Zealand, so the only thing I will be getting is 4-5 weeks placement, so it won't be enough for a person to get understand the things that is happening, so I have worked as a health care assistant for 1 year, and I know what's happening in a rest home, and I know the roles of the nurse, and yeah role of the HCA so, I know what to expect from my, if I am like if I, probably I will be a nurse, so I know what to expect from my HCAs.*

Deep, although she had mentioned she felt the HCA role was a low level job, she found positives out of working in the role, she said:

*it will help me a lot, because I know at this level how the residents are feeling, so if I will be a nurse then I can know from the bottom, like how they are feeling, how they are living, so I can better understand them in my nursing profession, so I think it's a positive experience as well..... its helpful for me as well in the future, now I'm seeing, in future I will do*

Shez also felt the HCA role gave her capital for the future role as an RN, stating

*Well first and foremost we cannot work as a nurse immediately here in New Zealand, so working as a health care assistant, could be one way of bridging the gap of practising nursing, and you know getting into that pathway, so working as a health care assistant could be a bridge, for us to do, I mean you know if you get to familiarise with, familiarise yourself with the setting, New Zealand setting, and yeah that's one of the big help, one of the biggest advantage of working as a health care assistant, you get to familiarise yourself, with the set-up, with how New Zealand you know the rules, the law about the health care, yeah things like that.*

Whilst some participants felt working in the HCA role was useful capital for their future career as an RN, there may also be a degree of acceptance that this is their trajectory. The actions of the ORN are interest orientated as they learn from their time in the field. The following statement from Jose shows how she is learning to be an HCA in ARC. She is learning the habitus of the field from working in the field.

*Actually the basic cares we know, as nurses we know the basic cares and how to do them, but actually in India we don't have change into pyjamas in the afternoon, getting dressed in the morning, if they're at home they'll be in the normal dress, they won't get dressed up like that, so I didn't know that all these cultures in residents home, these types of things I learn from health care assistant, but the basic cares like wash, giving them a shower, cleaning them as nurses we know that.*

## **Conclusion**

The trajectory for an ORN working as an HCA in ARC is downward in terms of the position held in the field. Part of moving into a new field is giving up capital that is not required and accruing new capital in order to fit in and improve position in the field. ORNs that choose to work in ARC as HCAs accept this downward trajectory and appear to believe that it is worth it to help them reach their long term goal of becoming an RN in New Zealand.

While the ORN believes the game is worth playing, they misrecognise that they are part of a class struggle which leads to the reproduction of social order.

## **Chapter Eight - Discussion, Conclusion and Recommendations**

The aim of this research was to benefit ORNs by investigating the situation where they were working as HCAs in ARC in New Zealand. The research question formulated from the gap in literature was “What influences the practice of overseas registered nurses who work as health care assistants in aged residential care in New Zealand”?

This chapter firstly provides an overview of why this research is important. A discussion of the findings follows, describing three major trajectories of what influences practice: developing a sense of belonging, capital configuration and a game worth playing. The discussion includes how this study’s findings are situated within existing literature, by contrasting the results with previous research. In essence, the findings showed that for the participants in this study, the practice of ORNs working as HCAs in ARC was influenced by the need to “fit in” and gain a sense of belonging. There was a struggle for symbolic power as the ORNs as HCAs competed for position in the new field with HCAs who were not ORNs. The ORNs as HCAs unconsciously used reconversion strategies to convert embodied cultural capital to be valuable in the field, to build relationships, feel valued and gain a sense of belonging. The practice of ORNs working as HCAs was influenced by the need to feel valued, fit in, and feel like nurses again.

This chapter also discusses the implications of the research findings and argues that there is an opportunity for change. This change would involve the collaboration of the broader fields of power to reduce symbolic violence and support a pathway that meets the needs of ORNs, the ARC sector, and the nursing profession in New Zealand.

### **Why this study is important**

This research aimed to benefit ORNs by revealing the hidden part of the transition (for some nurse migrants) to New Zealand, rarely discussed and lacking in the literature. A critical approach using Bourdieu's theory of practice underpinned this research (Bourdieu, 1977). Bourdieu's theory of practice enabled the researcher to consider how ORN

participants' background and culture influenced their practice as an HCA in ARC in New Zealand. The research identified three themes; a struggle for power, personal and professional habitus, and a game worth playing.

Since commencing this research, the Covid 19 pandemic has reduced the migration of ORNs to New Zealand. New Zealand borders were closed for those who were not citizens or residence visa holders from March 2020 for over two years. Consequently, the number of migrants traveling to New Zealand to study in tertiary education decreased from 54,660 in 2019 to 36,770 in 2021, a reduction of 33%. This included 22% of students studying off shore in 2021 compared with 3.7% in 2019 (Smart, 2021). This will have impacted on the availability of ORNs to work as HCAs in ARC. As the New Zealand borders open up to international students and ORNs, it is timely that the findings from this research can be integrated into future workforce planning for ORNs coming to New Zealand. Timely too, are the changes announced in August 2022 by NCNZ to the pathway for an ORN to register as a nurse with the NCNZ (Nursing Council of New Zealand, 2022a). These changes include NCNZ providing culturally appropriate education and directly assessing the competence of an ORN through an online examination and an objective structured clinical examination (OSCE). These changes will be enacted by January 2024 and consequently the existing CAP will no longer be delivered (Nursing Council of New Zealand, 2022a).

### **An Integrated Summary of Findings**

ORNs as HCAs lose symbolic capital and identity because they can no longer work as RNs, which for participants in this study, contributed to feeling like they did not belong. The findings from this study portrayed a downward trajectory that began with having no sense of belonging and not fitting into a new field of practice and a new role. The findings suggest that the need to fit in and gain a sense of belonging influenced the practice of ORNs working as HCAs. The ORNs as HCAs were motivated by the need to be valued by residents and staff, so converted one form of capital to another to build relationships. For example, respecting older people (an embodied cultural capital), was used to build relationships to increase social capital in the field. The social capital provided benefits for the ORNs as HCAs. Firstly, it enabled them to provide physical and emotional care in the

absence of each resident's family. Secondly, the social capital provided a sense of belonging as the relationships with residents imparted a family feeling in the absence of their own family.

The ORNs were working in a new field. Unsure of its habitus, they had to learn the rules of the game to gain a sense of belonging as they adjusted to their new role. In this study, the need for a sense of belonging evoked tension between their personal and professional habitus. This tension revealed itself as the ORNs appeared to need the relationships with the residents for their personal benefit, potentially leading to crossing professional boundaries.

ORNs as HCAs differ from other HCAs who are experienced in the field because of their background, culture, nurse education, and experience. The findings illustrated a struggle for position in the field between experienced HCAs and the ORNs as HCAs. This struggle contributed to ORNs as HCAs feeling like they did not fit in and often did not want to attend work.

They continued to use practices learned during their nurse education and experience, such as empathy, understanding, and assessment skills, despite being unable to carry out many procedures such as inserting a urinary catheter. Once the field was navigated and they began to adopt the team habitus, they built new social, cultural, and symbolic capital. Completing the medication competency appeared significant for them because it restored some symbolic capital of being a RN. Their trajectory began to move upwards and for some, it felt like they were working as nurses again, and they believed this would help them in their future role as an RN.

## **Discussion of Findings**

The findings of this research illustrated how ORNs working as HCAs, without knowing, appeared to question the doxa in the ARC field as they are neither RN nor are they an experienced HCA. The doxa, defined as how things are, is part of habitus, and when the un-discussed is critiqued, the truth of doxa is disclosed. This can become an opportunity for change (Bourdieu, 1977). The discussion outlines and critiques the implications of the

findings of this research, to reveal the doxa which is hidden from participants in the field. The following section will discuss the practice trajectory of the participants in this research.

## **The Practice Trajectories**

The findings from this study's participants showed that ORNs who worked as HCAs in ARC were on a downward trajectory as they moved from one healthcare field to another (Figure 14). The trajectories influenced by personal and professional habitus and reconversion strategies to improve position in the field, were developing a sense of belonging, capital re-configuration, and a game worth playing. The following section discusses these three significant trajectories in this study's findings.

### **Developing a sense of belonging, influences practice**

Initially the trajectory was downwards in terms of this study's participants working in a lower position in the nursing hierarchy than in their country of qualification. It is a lower position in the hierarchy because they report to an RN in the HCA role. As a result of a downward trajectory, there was a loss of symbolic capital and identity as an RN. While navigating their way in a new field and a new role, they were subjected to symbolic violence, often felt devalued, disempowered, and struggled to fit in. The struggle was not only one of disempowerment due to loss of position but not knowing the "rules of the game" in the new field was also significant. As Bourdieu emphasised knowledge of the rules is a form of cultural capital that is unequally distributed between the dominators and subordinates (Swartz, 1997).

Looking more broadly, the ORNs as HCAs found themselves in a social space that was a field of class struggles. A class struggle is a struggle for some forms of power, for example symbolic, cultural, and social power. One example of a class struggle was when Junu was spoken to in a hostile manner by another HCA. Junu was overpowered by someone more experienced in the role of HCA. She was left to feel like a lower-class citizen, where she chose to accept the behaviour and not complain. The social space is a space of positions held and positions to be held, where trajectories across social boundaries can be analysed

(Bourdieu, 1984). The social space is a conceptual space with a structure of symbolic classifications and positions organised according to capital and habitus. The class system stems from capital distribution, including valuable resources and associated power (Bourdieu, 1977, 1984). According to Bourdieu (1987), classes are constructed throughout society and generally consist of agents with similar backgrounds who come together as a group. The volume and composition of capital and trajectory are continuous dimensions in class structure (Bourdieu, 1990).

This study's findings were consistent with Bourdieu's assumption that class structure is about the division of labour that forms a system. No longer working as an RN and therefore not in the "class on paper" known as a profession, the ORNs as HCAs, without realising it, constructed a new "class on paper." The logic of the field guided the process of this construction. As lifestyles are socially ranked, and cultural differences are markers of class difference, the participants in this study are labeled in a certain class before entering the new field of ARC. As Bourdieu (1985) claimed, individuals in a social space that are markedly different and therefore "distinct" from others are likely to be in the centre of symbolic struggles, which are, in effect, class struggles or struggles for symbolic power. Add the downward trajectory and ORNs as HCAs found they were not part of a group. Not an RN, not an experienced HCA, a different background, lifestyle, culture, and trajectory that brought them to the role left them disempowered, floundering in a social space, not knowing where they belonged.

The trajectory evident in the participants' explanations showed a struggle for position before finding some sense of belonging. Findings from this study showed that ORNs as HCAs are subjected to symbolic violence exhibited by verbal abuse from staff and residents. Brunton et al. (2020) presented similar findings when investigating the experiences of migrant nurses working as RNs in New Zealand. Racist remarks from patients and staff questioning their capabilities, led to some ORNs losing confidence and feeling like they did not belong (Brunton et al., 2020). In line with this study, research also indicates that whether it be as an HCA or an RN, entering a new workplace would bring challenges for migrants in understanding the organisational culture, understanding the role, and gaining a sense of belonging (Chun Tie et al., 2019; Xiao et al., 2014).

To gain a sense of belonging, this study's participants used attributes from their personal and professional habitus to build relationships. Habitus is the dispositions, the deep-seated habits that a person has that help them navigate the social world. These dispositions are carried out without thought and are the natural way to do things. The findings from the ORN participants in this study showed that their culture, which is part of their habitus, guided them to treat older people with respect, and they cared for them the same way they would care for a family member. These findings are consistent with a study in New Zealand, which also demonstrated that Filipino aged care workers were passionate about their work, and the care they provided was as it would be for their parents (Lovelock & Martin, 2016). A study in the UK and Ireland found that migrants and residents they cared for felt that their relationship was more than providing physical care. There was also clearly a friendship, a sense of companionship, and a familial feel developed (Walsh & Shutes, 2013). The study by Walsh and Shutes is consistent with the findings from this study. Additionally, the connections the participants in this study made with the residents, also gave them a sense of "family" when they missed their own families who remained overseas.

Developing close connections as if residents are family was also found in this study, but this is not exclusive to migrants working in ARC. Law et al. (2019) interviewed non-migrant HCAs in dementia care. Participants in this British study felt that close relationships with clients were crucial, and that it was impossible not to get attached due to their close personal care. Comparable to this study, participants in the study by Law et al. (2019), stated that they treated residents like family, thus supporting the claim that these close relationships are beneficial. A systematic review of the international literature related to HCAs and resident satisfaction in long-term care, supported the notion that the interpersonal relationship between staff and residents is crucial to providing exemplary care and meeting residents' needs; including showing care beyond the provision of physical tasks (Li et al., 2021).

New philosophies of care such as the Eden Alternative, aim to increase the quality of care provided for residents, particularly the non-physical care such as spirituality

(wairuatanga<sup>11</sup>) and belongingness, as in family (whanau<sup>12</sup>) oriented (Anderson & Spiers, 2015). The philosophy includes creating groups of residents cared for by the same staff to create a sense of family. This philosophy of care can take its toll as carers are burdened with responsibility and lack the fellowship of working with others when caring for residents (Anderson & Spiers, 2015). Despite this risk, the latest research advocates for more positive relationships between care staff and residents (King & Miller, 2021). These close relationships with residents should not be at the expense of staff well-being. For ORNs as HCAs struggling to form positive relationships with team members, finding some solace in the family-type feeling with residents is understandable.

The ORNs as HCAs are not regulated and they are not bound to maintain professional boundaries set by NCNZ, although they work under the guidance of an RN (Nursing Council of New Zealand, 2012a). Not only do ORNs as HCAs lose the title of a professional, but potentially there could be an erosion of their professional habitus if standards of practice do not bind them. While professional boundaries are expected to be maintained by an RN, close relationships are necessary for the role of an HCA in ARC. The relationships developed between ORNs as HCAs and residents, appeared twofold and were central in the struggle for power. Firstly, the participants gained a sense of their position in the field as the relationships which are crucial according to Law et al., (2019) and Li et al., (2021), enabled the ORNs as HCAs to provide care. Secondly, building close relationships provided the ORNs as HCAs with social and embodied cultural capital, contributing to their sense of belonging in the field. This cultural capital included improving their English language and gaining linguistic capital as they spend time with the residents. Gaining social and cultural capital afforded them cultural power, as their position in the field was being established.

### **Capital Re-Configuration**

The trajectory for ORNs into the role of an HCA is a transverse move to another healthcare field in a new country but a downward trajectory in a different (lower) position (Figure

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<sup>11</sup> Wairuatanga is used as a term meaning spirituality. It is believed to be interconnected with all aspects of life and is viewed by Māori as vital to health and well-being (Spirituality and Well-being Strategy Group, 2013)

<sup>12</sup> Whanau is the word used for family or family group and includes extended family and those connected to the family, often with no kinship (Te Aka Māori Dictionary, n.d.- c)

14). This trajectory results in the re-configuration of capital as some capital is not of value in the new field, and new capital needs to be accumulated to continue developing an upwards trajectory. Capital re-configuration was part of the struggle for power for ORNs as HCAs because cultural capital that gave them symbolic power was no longer valued, leaving them feeling disempowered. From a Bourdieu perspective, one would expect that possessing institutionalised and embodied cultural capital would enhance employment opportunities (Bourdieu, 1986b). The findings from this study show a plethora of knowledge, skills and attributes (capital) that ORNs bring to the field of ARC. This cultural capital more than likely contributed to them gaining employment as an HCA, but this is not the role they are educated to do. Some of the capital accumulated while working in acute settings overseas is not required in ARC, which could be classed as unused or wasted capital and a loss of cultural power. However, what influenced the practice of ORNs as HCAs in this study was the institutionalised and embodied cultural capital they brought to the role, that was valuable in the field. The following section will discuss the participants' valuable capital, which included emotional capital and nursing knowledge. The discussion also considers the devaluation of capital and regaining symbolic capital.

### ***Valuable Capital***

The findings show that the practice of ORNs as HCAs is influenced by personal and professional habitus. The habitus of a nurse is an accumulation of acquired knowledge, experience, and commitment to professional values driven by objective structures, such as professional standards and protocols. The dispositions developed as part of personal and professional habitus, became embodied cultural capital, and are helpful in navigating and improving position in ARC. The associated caring and emotional dispositions, which are subjective, and according to Bourdieu (1977), are more profoundly shaped by personal habitus, were shown significantly within the findings of this study.

Caring about people's well-being is central to everyday nursing practice and is likely what makes a person become a nurse in the first place (Akgun, 2019; Porr & Egan, 2013). A caring nature is an embodied cultural capital and an asset for transnational migration in healthcare, particularly nursing or HCA roles (Kelly & Lusic, 2006). In the struggle for cultural power the participants in this study, demonstrated a "caring mentality" and were

able to use this asset to strengthen their position in the field. This attribute was demonstrated in the findings of this study, primarily through descriptions of acts of empathy and understanding and is recognised as emotional capital (Cottingham, 2016).

### ***Emotional Capital***

Findings from this study demonstrated how emotional capital is valuable and an asset when caring for residents. The participants appeared proud to be able to interpret the emotions of the residents and to be able to show empathy and understanding where appropriate. Showing empathy and understanding helped build therapeutic relationships and "allowed" the ORNs as HCAs to provide care. This finding is comparable to the results of Rodriguez (2011), who found that aged care workers acquired job satisfaction through emotional attachments and recognised that these attachments led to residents' consent and compliance. Residents' permission to care for them is particularly significant for the ORNs as HCAs, in a field where there is racism and discrimination from residents. There is a shift in the power dynamic as emotional capital, facilitates a caring encounter between the ORNs as HCAs and the resident. Emotional capital is the bargaining power between the carer and the cared-for. Virkki (2007) acknowledged this is the carer knowing how to play the game. The findings from this study are consistent with Virkki as the ORNs as HCAs used emotional capital to play the game.

Emotions are embodied cultural capital and are regarded as assets used for success in a given field (Cottingham, 2016). What constitutes emotional capital varies depending on the organisational context; in other words, what is valuable in the field. Bourdieu (1986b) suggested, capital valuable in one field may not be in another. However, the findings from this study showed that emotional capital was transferable from one field to another, as the ORNs moved from working in acute care settings overseas to ARC in New Zealand.

The findings from this study's participants were congruent with Virkki (2007), who explained the ability to show empathy and understanding, positively affected a person's well-being and is valuable emotional capital in a caring role. Virkki (2007) broadens Bourdieu's work by considering emotional capital as an asset. She argued that emotional capital is used at the core of the professional habitus, to protect one's self-worth while

providing care to clients. Virkki (2007) added that by using emotional capital, the carer maintains control of interactions between them and those they care for. This study's findings are congruent with Virkki (2007), as the ORNs functioning as HCAs, used emotional capital to gain control and find a sense of worth. They were unconsciously within a complex struggle for symbolic, cultural, and social power.

Emotional capital is the ability to control one's emotions during complex interactions with clients or staff. Often referred to as resilience, emotional capital is an asset that protects a person from humiliation (Rodriquez, 2011). Still, it can lead to poor health, including stress and burnout (Delgado et al., 2017). While not using Bourdieu's work, the research by Rodriquez (2011) is an example of how emotional capital is used as an asset in a caring role. The participants consistently found their emotions a resource for managing stress in their work with residents (Rodriquez, 2011).

This study's findings demonstrated the use of emotional capital and the stress involved in response to the power interplay between the ORNs as HCAs and the staff and residents. Meaning this study's findings are congruent with the findings of the integrative review by Delgado et al. (2017). Not wanting to reveal their feelings to work colleagues, the participant reactions were often crying, not wanting to go to work, and not wanting to complain. One participant (Rose) even said, *"You have to handle, you have to make yourself hard."* This response is what Hochschild (2012) described as "emotional labour", which described the burden on an individual when emotions are suppressed, to appear to be coping.

Amidst the struggle for power the ORNs as HCAs were expected to act and feel in a certain way to meet the needs of residents and the organisation, they used emotional capital to "fit in" and be socially accepted. While contributing to social reproduction, they played the game and learnt the habitus of the field. It is argued from the findings of this study that support is required at an individual level for migrants and residents when relationships are being built, to ensure safe connections are created and quality of care is maintained. The findings from this study, support the suggestion by Walsh and Shutes (2013) that

education, cultural support, and procedures for addressing discrimination, are all required at a broader organisational level.

### ***Nursing knowledge as capital***

The findings from this study suggested that the practice of ORNs as HCAs is likely to be different from an HCA who is not an ORN, because a professional nursing habitus influenced it. The practice of ORNs as HCAs in this study is influenced by the professional nursing habitus, which is different from other health care practitioners. The participants in this study brought with them nursing knowledge and used this when assessing residents. They used their nursing knowledge to interpret assessment findings and decide their actions. Recognising and understanding nursing knowledge as cultural capital helped interpret the data in this study as the participants described their practice.

The ORNs as HCAs in this study demonstrated the ways of knowing as discussed by Carper (1978) and Chinn and Kramer (2018) because it is part of their nursing habitus. For example, when Shay assessed a resident after a fall, she assessed pain in her hips. She knew the resident's background of a hip replacement. Shay completed vital signs and blood glucose monitoring and assessed for symptoms that could have caused the fall, such as dizziness. She also observed the resident for any physical injuries. Shay demonstrated empirical knowledge or the science of nursing through data collection, such as vital signs and blood glucose monitoring, and an understanding of the implications of a previous hip replacement. She demonstrated aesthetic knowledge or the art of nursing as she considered the significance of her findings. This aligned with the work on knowledge development in nursing by Chinn and Kramer (2018), as the meaning in the situation was understood, and Shay decided on care. Shay commented that it felt like she was working as a nurse, perhaps because it is part of her professional habitus ingrained in her. This ingrained professional habitus could evoke symbolic and cultural power in the field, particularly over an HCA who is not a nurse. This may be important as cultural capital becomes of value in the field, it could reinstate symbolic capital for the ORN as an HCA.

All participants in this study described care encounters, including assessing residents and making decisions on findings. It is argued here that the nursing knowledge

(institutionalised and embodied cultural capital) the ORNs bring to the HCA role, could be fully recognised and utilised to improve the quality of care in ARC. The job description of an HCA is devised by the employer and not all ARC facilities have protocols that allow the ORNs as HCAs, to take vital signs and complete blood glucose monitoring. If processes for demonstrating competency were implemented, these skills could be more widely utilised. Opportunity for ORNs to complete nursing procedures such as urinary catheter insertion and passing a nasogastric tube may also be appropriate. This would reduce the loss of cultural power and the risk of deskilling ORNs, while filling a nursing workforce gap.

### ***Devaluation of Capital (Brain Waste)***

The ORNs in this study had knowledge, skills and attributes required in ARC. However, these were not utilised effectively, which was a devaluation of capital and a loss of cultural power. An analysis of immigrants coming to New Zealand referred to this underutilisation of capital as “brain waste,” which is a loss to the individual, employers, and the country (Apatov & Sundaram, 2020). Similarly, a study from Sweden suggested brain waste is seen as a devaluation of human capital, when qualifications and skills learned and practiced in a different country are not recognised (Salmonsson & Mella, 2013).

Interestingly Apatov and Sundaram (2020) analysed immigrants from the Asia-Pacific Economic Corporation (APEC) countries living in New Zealand. Apatov and Sundaram found that most people from countries in this consortium were not at risk of brain waste as they were employed in jobs equal to their skill level. However, immigrants from the Philippines and Indonesia were more likely to work in lower-skilled jobs in New Zealand. The report suggested that these countries are less developed, further away, spend less on education, and have no colonial links to New Zealand. It is argued that the reasons stated in this report for being employed in lower-skilled jobs in New Zealand, do not correlate, as the Philippine government encourages emigration of nurses, by actively ensuring there are more nurses educated at degree level than are required in the Philippines (Salami & Nelson, 2014). Noteworthy too is that India is not part of APEC and is therefore not included in this report. However, there is no reason to believe that statistics would not be similar to those of the Philippines and Indonesia, despite past colonial links. This is relevant to this study because participants were from India and the Philippines who are

employed in jobs lower than their knowledge, skill and experience level. Regarding ORNs, perhaps the responsibility lies with agents and education providers, who support and encourage immigration from the Philippines and India, prior to the migrant meeting the criteria to register with the NCNZ.

### ***Symbolic capital***

Part of capital configuration involved gaining new capital. Gaining competency to administer medications to residents appeared to be significant for the participants in this study. The overwhelming feeling was for those HCAs gaining medication competency, made them feel like they were working as nurses again. All but one participant in this study had completed it, and it appeared to change their position in the field, as they were regarded as senior once they were administering medications. For example, Shay said, *"I was given the medication competency, and now it feels like I am just doing my nursing work in the Philippines and here as well."* Therefore, gaining the medication competency reinstated some symbolic and cultural power for the participants.

Medication administration is a complex task requiring knowledge of the drugs, expected effects, and side effects. It is delegated to care assistants globally, particularly in community settings, because of a shortfall in registered or licensed staff (Bengtsson et al., 2021; Craftman et al., 2016; Shore et al., 2022). The findings from this study were consistent with the global situation as the HCAs were delegated the task, allowing the RN to be free to complete other work.

Medication administration requires education and systems support, to ensure that quality of care is maintained for the HCA and those responsible for delegating the task (Bengtsson et al., 2021). ORNs as HCAs are likely to be suitable delegates due to their background as nurses. While working closely with residents, they may be able to relate any new observations or clinical symptoms to drug side effects. As Shay explained, it could be argued that the person is working as a nurse, not an HCA. On the other hand, there may be an expectation that an ORN has the knowledge and skill to make clinical decisions related to medication administration, but this may not be the case. Medication errors in ARC have been linked to care assistants, among other reasons, but there is no

differentiation made in the study as to whether the care assistants are ORNs or not (Bengtsson et al., 2021). This is an area that requires further research.

There is also a grey area in that the RN in an ARC is expected to delegate medication administration to the HCA; they do not have any individual choice because it is an organisational delegation (Craftman et al., 2016). The study by Craftman et al. (2016) was in Sweden, and it is relevant to this study because the lines of delegation from RN to HCA are the same in ARC in New Zealand. Without good lines of communication, the delegation process could be vulnerable. Therefore, transparency is needed to ensure the RN is made aware of individual accountability when delegation is from an organisational position. An extensive retrospective review was undertaken in New Zealand ARC. Clinical notes from Medimap (the electronic prescribing system) were reviewed when a medication was omitted. The study found that many documented omissions did not provide a rationale (Garratt et al., 2020). The study acknowledged that these decisions could stem from good clinical decision-making, but the omission is recorded as an error because the rationale is not provided. The point here is that while medication administration is a delegated task and the RN is responsible for this, there could be a high level of expectation on the HCA as an administrator in making and documenting decisions. The governance framework for the delegation of the administration of medications from the RN to an HCA in New Zealand, is provided by the Medicine Care Guide in Residential Aged Care (Ministry of Health, 2011), Direction and Delegation Guidelines (Nursing Council of New Zealand, 2012a), and Guidelines for Nurses on Medication Administration (NZNO, 2018). More research is required to review the implementation of the medication administration guidelines, to ensure safe practice and good quality care for residents. Research is also required to determine the understanding of direction and delegation guidelines to help protect the delegator and delegate.

### **A game worth playing**

For participants in this study, working as an HCA in ARC was seen as an opportunity to work in healthcare with the expectation that it may lead to future opportunities. As Shez stated:

*one of the biggest advantages of working as a health care assistant, you get to familiarise yourself, with the set-up, with how New Zealand you know the rules, the law about the health care, yeah things like that.*

This outlook compared with literature which showed that highly skilled workers often have their future in mind when taking a job in the ARC sector, including the prospect of permanent residency (Kubiciel-Lodzińska & Maj, 2021; Lovelock & Martin, 2016). More specifically, the findings from this study are consistent with the research by Kubiciel-Lodzińska and Maj (2021) in that participants viewed working in ARC in a lower-skilled job, as an opportunity to gain experience that may provide openings in the future. This is also congruent with Webb (2015), whose research showed there was more to working in a lower-level job than gaining experience. Having a job in the sector likely builds social capital, which may give rise to job opportunities in the future. Bourdieu (1986b) suggested there are unconscious strategies to building functional relationships that develop social capital. This social capital gives the ORN as an HCA cultural power as they establish themselves in a position to influence which may help them secure a New Zealand RN position in the future.

For the participants in this study, seeing the HCA role as beneficial for the future as an RN in New Zealand, may be a misrecognition of social reproduction and an acceptance of the position the ORNs find themselves in. The practice of nursing is socially shaped and differs from country to country. The HCA role in ARC is generally task-orientated, as discussed in the Australian study by Ludlow et al. (2020). This task-focused role is the same in New Zealand and may provide the ORN with an imprecise view of nursing culture in New Zealand, which is more holistic. A study in the UK found that the values and expertise of nurses from overseas working in a care home as care assistants, were often not appreciated and on the contrary, they were moulded into the culture of performing tasks (Kadri et al., 2018). This study has shown that ORNs as HCAs learn to be an HCA and are drawn into the team habitus, enabling them to gain a sense of belonging. This could erode their professional habitus and could be detrimental to their future RN role. Further research would be helpful to compare ORNs who come to New Zealand straight into a CAP and an RN role with those that work as an HCA before completing a CAP.

For the ORN participants in this study, there was an *illusio*, that is, a belief that the game was worth playing. In comparison, Chun Tie et al. (2019) studied international nurses' integration into the workforce as RNs in Australia. They identified a theory of playing the game, similar to that described by Bourdieu (1977). The study by Chun Tie et al. (2019), omitted to identify whether the participants thought the game was worth playing, although they did identify that both local and ORNs required ongoing culturally appropriate support to aid migrant integration into the workforce (Chun Tie et al., 2019). This study's findings support this recommendation to ensure that the integration of migrant nurses (the game played) is more straightforward, fair, and supportive. This could include a pathway to becoming an RN in New Zealand for those that do not yet meet the criteria for NCNZ registration. These ORNs have previously travelled to New Zealand to study at tertiary education providers, or travelled with partners who are studying. This pathway could be an internship provided by a partnership between tertiary education and healthcare providers such as ARC. This could ensure that the game is worth playing for all participants. This has implications for the broader fields of power, particularly tertiary education providers, Immigration New Zealand, the ARC sector and NCNZ.

This discussion of the findings has drawn attention to three practice trajectories developing a sense of belonging, capital re-configuration, and a game worth playing. Overall, the discussion has highlighted a struggle for symbolic, cultural, and social power as ORNs as HCAs move on a downward trajectory into a role below the level of their education and experience. The critical points in the discussion are firstly that developing a sense of belonging is significant, and support may be beneficial for ORNs to do this in a safe way with staff and residents. Secondly, the difference between ORNs as HCAs and HCAs who are not ORNs needs to be acknowledged, as ORNs bring an array of knowledge, skills and experience to the role. Culturally appropriate support for staff and newcomers would aid integration into the workforce.

The findings showed that in ARC, social order is maintained as the field maintains and reproduces systems contributing to marginalisation. The broader fields of power contribute to the social order and the downward trajectory of the ORN. Organisations such as Immigration New Zealand, the tertiary education sector and the ARC sector, work

individually to meet the needs of their field, without conscious awareness of the impact on the individual trajectories they have power over. The findings from this study would support a solution for a partnership between these sectors to provide an employer-sponsored visa programme that meets the needs of ORNs and the employing organisation (Xiao et al., 2014). This type of programme could provide ORNs with improved job and visa security, reduce marginalisation and ensure the education, skills, and experience they bring to ARC are used appropriately.

### **Implications for Practice – Broader Fields of Power**

The findings from this study demonstrated that loss of symbolic capital, adjusting to a position perceived as inferior, and the associated power struggles, were part of the trajectory to fitting in the field of ARC in New Zealand. The loss of symbolic capital was because the ORN could not work as a nurse in New Zealand, due to not yet meeting the NCNZ requirements to register. Most participants in this study travelled to New Zealand to study at a tertiary education provider and chose to work as an HCA in ARC to support them financially, until accepted on a CAP. Two participants travelled with their husbands, who had studied at a tertiary education provider in New Zealand. ORNs choose to work as HCAs; there is no pathway to state they must work as an HCA before nurse registration in New Zealand. There appears to be an acceptance that this is the natural order of things, and there is misrecognition of the symbolic violence this renders. The misrecognition is at multiple levels of society, where the broader fields of power play their part by contributing to the reproduction of class structure. These power fields include the nursing profession, the New Zealand government (Immigration New Zealand), tertiary education providers, and the ARC sector.

#### ***The implications for the nursing profession***

The NCNZ is the regulatory body for nurses and does not regulate the HCA role. As a regulatory body, the NCNZ is in a position of power under the HPCA Act (2003), with its primary focus on public safety. The NCNZ's role is to set the criteria for entry onto the register of nurses, assess applications of ORNs, and accredit the pathway that ORNs must complete to register and work as RNs in New Zealand. There is a tension for NCNZ

between the priority of protecting the public and the need to reduce the barriers to registration for ORNs, at a time of nurse shortages. The CAP has recently been under review, and a new pathway for ORNs is expected in 2024. However, it is recommended that professional bodies should also advocate for the appropriate use of the knowledge, skills and experience that ORNs bring to the workforce, including those ORNs not yet registered nurses in a host country (Salami & Nelson, 2014). Therefore, for NCNZ to support a pathway for those ORNs who do not yet meet the criteria for registration, is recommended.

The NCNZ competency framework cannot be ignored when considering nursing as a profession. This framework includes four domains of practice: Professional Responsibility, Management of Nursing Care, Interpersonal Relationships, and Inter-professional Healthcare and Quality Improvement. A definition of competence is *"the combination of skills, knowledge, attitudes, values, and abilities that underpin effective performance as a nurse"* (Nursing Council of New Zealand, n.d-a). Competency is constructed through habitus, and while dependent on cultural and social capital, it becomes ingrained and carried out without conscious thought, indicating the nurse has a feel for the game (Bourdieu, 1977, 1998). Therefore, a competent nurse would demonstrate the habitus of a nurse through their actions. A competent nurse, like all professionals, is an actor in the field of the profession, a person who has developed a habitus in which they occupy a position by adjusting to the objective structures set up in that field (Bourdieu, 1977). The systems of hierarchy and symbolic power are internally reproduced within nursing, legitimised by the profession.

A recommendation is that the Professional Development Recognition Programme (PDRP) structure is used. Patricia Benner was one of the first nursing theorists, who discussed competency and introduced the Dreyfus model of skills acquisition through five performance levels from novice to expert (Benner, 1982). In New Zealand, these levels are used to support PDRPs to recognise and reward the expertise of a nurse, which in turn depicts a particular position in the field of nursing and the broader field of healthcare (Nursing Council of New Zealand, 2013a). Through the PDRP, a nurse can show evidence of competence, proficiency, or expertise and receive remuneration for the level. If an ORN

who does not yet meet the criteria to register as a nurse with NCNZ, was employed in an internship or programme of study similar to the new graduate programme, evidence of competency could be demonstrated by the end of the internship. It is also recommended that NCNZ, which approves nursing curricula, ensure working in multicultural teams is included in nursing education programmes. This is discussed further in the following section.

### ***The implications for the tertiary education sector in New Zealand***

Tertiary education providers that offer pathways for ORNs that do not lead to nurse registration and New Zealand residency, legitimise symbolic violence because these pathways often lead to a downward trajectory. Most of the participants in this study, had completed either a Level 7 graduate certificate or Level 8 post graduate certificate or diploma in a health-related programme, which allowed them entry to New Zealand (as discussed in Chapter one, Migration to New Zealand). However, these pathways did not directly lead to registration as a nurse; hence they took HCA roles in ARC.

It is useful to consider Bourdieu's perspective as he stated:

Misrecognition of the social determinants of the educational career – and therefore the social trajectory it helps to determine - gives the educational certificate the value of a natural right and makes the educational system one of the fundamental agencies of the maintenance of social order (Bourdieu, 1984. p. 388).

Understanding Bourdieu's theory of maintenance of social order, gives rise to challenging the ways things are. Tertiary education providers give opportunities to ORNs to migrate, improve English, and learn about the New Zealand healthcare system. However, the educational route provided, contributed to the downward trajectory for the ORNs in this study. The downward trajectory is misrecognised and leads to the subsequent marginalisation of migrant nurses. Marginalisation is when society labels a group a "lower class" or of less value than other groups. Such marginalisation is globally recognised as a social determinant of health, leading to inequalities (Lynam & Cowley, 2007; Wilkinson &

Marmot, 2003). A national orientation programme for ORNs would support the reduction of inequalities, which can lead to marginalisation (Chun Tie et al., 2019). As NCNZ make changes to the pathway for registration as nurses for ORNs, it will be crucial to ensure the components of the CAP which support orientation, are maintained. It is recommended that for ORNs who do meet criteria for registration, they have an orientation programme which might also include content similar to that of the current new graduate programme in New Zealand. Components of this could be the same for those who do not yet meet the criteria for registration, including showing evidence of competency at the end of the programme.

Education providers are also responsible for providing New Zealand RNs with appropriate education to work in a multicultural team and support the integration of migrant nurses into the workplace (Chun Tie et al., 2019). This education needs to be integrated into the undergraduate Bachelor of Nursing programme and continued in post graduate study. While nurse education has a bicultural focus in New Zealand, which considers an indigenous worldview as well as a western world view, the fact that New Zealand is a multicultural society cannot be ignored. This is timely, as Te Pūkenga (the new national New Zealand Institute of Skills and Technology) begins to consult on and roll out a new national curriculum for the Bachelor of Nursing in New Zealand (Te Pūkenga, 2022). This new curriculum will need approval from NCNZ.

### ***The implications for the ARC sector in New Zealand***

ARC facilities are a field of conflicting forces that provide a social space where hierarchy and the associated struggles for symbolic and cultural power are evident. ARC in New Zealand has struggled to recruit a local workforce for many years, relying on migrants for RN and HCA positions. Unsurprisingly, an ORN who cannot gain registration as a nurse in a host country, might be an attractive employee in this setting. In employing the ORN into the HCA role, this study's findings suggest ARC managers may be misrecognising the symbolic violence this produces at a systemic and a personal level.

New Zealand has developed into a multicultural society and it appears there is very little education for nurses to learn about other cultures and how to work alongside people from

different cultures (Brunton et al., 2020). Suppose this education is not available for RNs in New Zealand. In that case, the staff in ARC likely do not have good role models to develop appropriate behaviour when working with people from other cultures. As previously stated, working in multicultural teams needs to be part of nurse education, but it is also recommended to be part of ongoing training for staff at all levels of an organisation.

Xiao et al. (2014) suggests that support for integrating ORNs into the healthcare workforce, is often non-existent or from a junior nurse who is often not culturally aware and may have racist attitudes when giving instructions. In the case of integration into ARC and the HCA role, this study's findings suggested that an experienced HCA often mentors ORNs as HCAs. It is likely that these staff do not have education in mentorship or in working with people from different cultures. Therefore, the tension revealed in this study between the experienced HCA and ORNs as HCAs as newcomers, is not surprising.

While Xiao et al. (2014) study investigated ORNs working as RNs in Australia, the same adjustment to a role that does not align with a skill set would occur when an ORN becomes an HCA. Xiao et al. (2014) also reported that adaptation to a role in a host country was more difficult when the skills of ORNs did not match the job they were employed to fulfill. When there is little support for migrant nurses to acclimatise to the new setting, the consequences are loss of self-esteem, humiliation, loss of identity, and hostility in the workforce, jeopardising teamwork and the quality of care (Xiao et al., 2014).

Chun Tie et al. (2019) report that the ORN is often embarrassed to ask for or accept assistance. This study showed that ORNs as HCAs might be embarrassed to ask for help, but when they do, they are expected to know because they are an RN. This attitude will stop them from asking for help in the future, resulting in the loss of symbolic capital as honour and reputation are at stake. It is recommended that a more inclusive organisational culture where staff diversity is recognised and used as a resource for all is promoted (Munkejord, 2018).

Literature suggests that HCAs should be supported in building close, strong professional relationships with residents. This support should include opportunities to explore emotions to maintain quality of care (Law et al., 2019). The findings from this study suggest that ORNs as HCAs would benefit from support while building rapport with residents. Support might include activities for relationships whanaungatanga (getting to know each other), so the ORNs as HCAs can explore what is essential for residents. Whanaungatanga stems from Māori culture and is transferable to all. It is not merely getting to know the resident, for whanaungatanga is getting to know each other to make connections in building rapport and is formed through shared experiences (Health Quality and Safety Commission New Zealand, 2019). In this study, the ORNs as HCAs demonstrated whanaungatanga when building resident relationships. However, it is recommended that specific activities which foster this concept, could help them integrate into the field and help nurture a sense of belonging.

### ***The implications for Immigration New Zealand***

Immigration New Zealand is the government department responsible for facilitating entry into New Zealand, by issuing either temporary or permanent residence visas. The participants in this study were given either a student visa that allowed them to work up to 20 hours a week, or accompanied partners on a student visa (Immigration New Zealand, n.d.-a). When issuing the visas to study, there is an unintentional consequence of a downward trajectory in the workplace. HCAs in ARC were not on the priority skills list for immigration, so these participants could not apply for New Zealand residency, until they had worked in an RN position in New Zealand for two years (Immigration New Zealand, 2021). If an ORN had the opportunity to apply for residency when offered the RN position, this would provide security for the ORN and may help attract more ORNs to improve nursing shortages. Even better would be for ORNs working as HCAs to be given New Zealand residency, considering the reliance on them to fill these positions. This would give them security adding to the likelihood that they will remain in New Zealand. Suppose ORNs come to New Zealand to study on an internship or programme of study that leads to registration. In that case, it is recommended that New Zealand residency be given to provide security and encourage them to remain in New Zealand.

## **Summary of Recommendations**

- Develop a framework for ORNs who do not yet meet NCNZ criteria for registration, to enable migration to New Zealand which leads to registration as a nurse. This framework to include a pathway such as an internship supported by NCNZ and tertiary education. Such a programme should be supported by an employer who will sponsor the ORN visa application.
- Use the existing Professional Development and Recognition Programme (PDRP) to support the suggested internship pathway.
- Develop processes to assess competency of ORNs when working in HCA roles to allow their skills to be more utilised, such as blood glucose monitoring, taking vital signs and passing urinary catheters.
- Include studying how to work in multicultural teams in nursing education programmes.
- Include working in multicultural teams in on-going training for all staff at all levels of healthcare organisations. Healthcare organisations to recognise cultural differences in staff and use this as a resource for all.
- Implement specific activities which foster whanaugatanga to better support ORNs to integrate into a new field and help nurture a sense of belonging.
- Provide orientation to the New Zealand healthcare system for ORNs who meet the criteria for nurse registration. Use components of the present CAP to support orientation in a programme similar to the present new graduate nurse programme.
- Issue a residence visa to ORNs when offered a permanent position in healthcare or a programme of study that leads to a permanent position in health care in New Zealand. This would recognise their value to the health workforce and provide security for the ORN.

## **Original Contribution to Knowledge**

The use of Bourdieu's Theory of Practice (1977) to analyse the practice of ORNs in an HCA position is unique and original in New Zealand. The theory enabled the researcher to

reveal the rich culture, background, knowledge and skills the ORNs brought to the role of HCA and subsequently, the health workforce in New Zealand. The researcher used the theory to interpret the data which revealed otherwise under-discussed aspects of the trajectory of some ORNs. Furthermore, the use of the theory has made visible the importance of change concerning ORNs' practice development and opportunities in New Zealand. This study provides an impetus for other researchers to use Bourdieu's Theory of Practice (1977) because it demonstrates the usefulness of interpreting the action of people in their everyday lives in a healthcare setting.

It is well documented that the transition to a new country for ORNs can be difficult due to long-winded migration and registration processes; adaptation to a new country and culture and understanding language and local colloquialisms (Chun Tie et al., 2019; Ho & Chiang, 2014; Zanjani et al., 2018). Nonetheless, this study contributes to the existing knowledge on nurse migration in several ways. Firstly, a hidden part of the transition for some ORNs, has revealed a downward trajectory that disempowered the ORNs to a position where they felt they did not belong. The findings suggested that the practice of ORNs working as HCAs was influenced by the need to fit in and gain a sense of belonging. Misrecognition of this trajectory is a concern, as it marginalises and devalues the knowledge, skills, and experiences ORNs bring to the workforce in ARC.

Secondly, this study revealed that the culture and background (personal habitus) of the ORNs as HCAs, influenced their practice which helped navigate the field of ARC. Their culture and upbringing helped them build relationships that provided a sense of belonging. In particular, the ORNs, as HCAs, created family-type relationships in the absence of their own family.

Thirdly, this study revealed that the practice of ORNs as HCAs was influenced by their nursing knowledge, skills, and experience (professional habitus), which they used to assess residents and make decisions on their care. Valuable capital such as emotional capital and nursing knowledge were used in everyday practice while caring for residents.

Fourthly, this study revealed that the ORN participants believed the HCA role would support their integration into New Zealand and subsequently into an RN role. This perceived benefit included understanding the New Zealand healthcare system and building linguistic capital. The English language skills accumulated while working as an HCA included healthcare system language as well as learning colloquialisms used by New Zealanders.

However, this study also revealed that the HCA role might not be helpful in the long run as there is a risk of erosion of the professional habitus of ORNs who work as HCAs. This erosion was revealed in two ways. As the ORN is immersed in the HCA role and developed a team habitus, they built close relationships with residents, which could lead to crossing professional boundaries. Furthermore, the knowledge and skills the ORNs possess that are not used in the HCA role, devalue capital and lead to brain waste. This study argues that without significant support for the ORN during this transition time, the risks for their future RN role may out-weigh the benefits in the long term.

### **Strengths and Limitations of this study**

The strengths of this study are attributed to the research methodology and the theory of practice by Bourdieu (1977). The methodology supported consideration of the structures of nursing in New Zealand, specifically in ARC, and in relation to the broader fields of power. The symbolic and cultural power held by the NCNZ, tertiary education, the ARC sector and the New Zealand government, are illustrated and the need for collaboration of these sectors to work in favour of the ORN and the healthcare workforce in New Zealand is highlighted. The theory of practice provided a framework to identify aspects of misrecognition and marginalisation. This is important because it revealed the barriers to becoming New Zealand registered nurses and the risk of professional erosion and devaluation of the knowledge, skills, and experience of ORNs. It also provided a voice for the unheard, questioning the system in which ORNs are recruited in New Zealand.

A limitation of this research could be that it was carried out in a small region of New Zealand (The Waikato and the Bay of Plenty), with participants who were associated with one Institute of Technology. The researcher acknowledges that ORNs who work in

other regions as HCAs may have different experiences, although literature was discussed which showed when ORNs transition to a new country, similar outcomes occur (Brunton et al., 2020; Chun Tie et al., 2019; Xiao et al., 2014).

Completion of this research could be timely because tertiary education institutes will no doubt continue to market to attract international students, as they did before the Covid 19 pandemic. As New Zealand borders open up, changes to immigration for ORNs may occur. The NCNZ is presently completing work to make changes to the pathway for ORNs to register as a nurse in New Zealand; therefore, this is an opportunity for this research to have an impact.

## **Further Research**

The world is for ever changing, and along with this comes new ideas, challenges, and the latest evidence for practice. Already acknowledged, is that this research took place before the Covid 19 pandemic; therefore, it would make sense to complete further research in this area post-pandemic when international students return to New Zealand.

To build on the original contribution to knowledge research to further understand the difference between the practice of ORNs as HCAs and those who are not qualified nurses, may support the recommendations that the ORNs knowledge, skills, and experience be recognised and used appropriately.

Concerning whether working as an HCA is of benefit or a risk for the RN role in the future, comparing practices of ORNs who have worked as HCAs with those ORNs that are employed straight into an RN position in New Zealand might give insight into whether the downward trajectory is worthwhile. If an internship or programme of study is developed and implemented for those ORNs who do not yet meet the criteria to register as a nurse in New Zealand, research to measure the outcomes of this internship would be beneficial.

Two areas of concern revealed in this study might benefit from further research. Firstly, analysis to review the implementation of medication administration guidelines should consider the differences between HCAs who are ORNs and HCAs who are not qualified nurses. If errors occur, it would be beneficial to know if this is more often in one particular

group. Secondly, research to study the understanding that RNs and HCAs in ARC have of the guidelines for direction and delegation might help improve the quality of care provided and protect those involved with the delegation of tasks.

## **Final Conclusion**

In summary, this research study has provided insight into one pathway an ORN may take when migrating to New Zealand. Previously hidden and rarely spoken about in everyday practice, this pathway is a downward trajectory and could lead to erosion of professional habitus and loss of cultural capital (brain waste). The pathway disempowers ORNs, and they find themselves amidst a complex struggle for symbolic, cultural, and social power and their position in the field. If ORNs who do not yet meet the criteria to register as nurses in New Zealand (as explained in Nurse registration in New Zealand for migrants, page eleven) are provided with a pathway that supports their integration while using their knowledge, skills, and experience, this downward trajectory and brain waste could be avoided. This research can have an impact to improve the transition for ORNs at a policy and practice level. At a time of global nursing shortages, the broader fields of power ought to work collaboratively to improve transition and provide better support for nurses who migrate.

## **Final Reflection**

*As I complete this research study, I cannot ignore its influence on my practice as a nurse, a lecturer, and a researcher and how the capital and habitus I bring to the research field influence the research outcomes. Consideration of my position within the research throughout has also broadened my understanding of how the outcome is impacted by the researcher worldview. This new understanding supported appropriate adjustments to ensure ethical principles and credibility were upheld. The research field is one I never thought I would belong to; but as I begin to find my sense of belonging, I can see how the theory of practice has enabled me to see the world with a different lens, a Bourdieusian lens. As Bourdieu (1991, p. 207) states, "The difficulty, in sociology, is to manage to think in a completely astonished and disconcerted way about things you thought you understood." My perspective of what influences the practice of ORNs who work as HCAs in ARC in*

*New Zealand has been enlightened and developed. More critically, my view has changed because I now know what the ORN brings to the role of an HCA and the workforce in New Zealand. I believe what has been revealed by this research is the hidden, rarely discussed pathway of transition for some ORNs. This research is to advocate for change for the benefit of ORNs who migrate to New Zealand and perhaps other countries. I will feel my civic mission is completed once change happens.*

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## Glossary

<b>Aged Residential Care (ARC)</b>	is a rest home, hospital or dementia care facility where a person resides to receive 24-hour care. This is mainly people over 65 years of age but in some cases it may include people aged between 50 and 64 years of age that require 24 hour care due to disability (Ministry of Health, 2020a).
<b>Competency Assessment Programme (CAP)</b>	is a facilitated programme of theory and practice to enable an overseas registered nurse to show evidence of competency to be able to register as a nurse with the Nursing Council of New Zealand (Nursing Council New Zealand, 2008).
<b>Enrolled Nurse (EN)</b>	In New Zealand an EN works under direction and delegation of an RN to support the delivery of nursing care in a variety of settings. The EN contributes to assessment, care planning and delivery of care to clients but the RN remains responsible for care planning (Nursing Council of New Zealand, n.d.-b).
<b>Health and Disability Sector Standard (HDSS)</b>	The Health and Disability Services (Safety) Act 2001 is the legislation that underpins the certification of health care services in New Zealand. Service providers including ARC are required to meet the HDSS under the Act. The HDSS sets out the steps providers need to take to ensure they are providing safe, quality services. It also outlines what people can expect from the services they receive (Ministry of Health, 2016a).
<b>Health Care Assistant (HCA)</b>	is a caregiver that is employed by the aged residential care facility to provide care according to a job description under the direction and delegation of a registered nurse (New Zealand Nurses Organisation, n.d.-b). The healthcare assistant is not regulated by legislation (Nursing Council of New Zealand, 2012a). A New Zealand Certificate in Health and Wellbeing (Level 3) is required as a minimum, to work in this role in an aged care facility (Careers New Zealand, 2022).
<b>Health Practitioners Competency Assurance (HPCA) Act (2003)</b>	is the legislation introduced to protect the public by ensuring that health professionals are competent and safe to practice (Ministry of Health, 2018).
<b>International English Language Testing System (IELTS)</b>	is a system used to determine English language proficiency through examinations in writing, speaking, listening and comprehension. IELTS is accepted by the Nursing Council of New Zealand at score level 7 across all bands within a 2 year period. (A score of 6.5 in writing will be accepted after August, 2022), (Nursing Council of New Zealand, 2022c).

<b>New Zealand Nurses Organisation (NZNO)</b>	is the largest professional organization for nurses in New Zealand. NZNO negotiate salaries and working conditions in its function as a trade union as well as providing professional and clinical support. Members include health care assistants as well as registered nurses (New Zealand Nurses Organisation, n.d.-a).
<b>Nursing Council of New Zealand (NCNZ)</b>	is the authority that regulates nurses in New Zealand, and is governed by the Health Practitioner’s Competency Assurance (HPCA) Act. The primary role of NCNZ is to protect the public by ensuring nurses are competent and fit to practice (Nursing Council of New Zealand, n.d.-c).
<b>Occupational English Test (OET)</b>	is a system used to test English language proficiency with examinations in writing, speaking, listening and comprehension which focuses on language used specific to particular occupations such as nursing. OET is accepted by the Nursing Council of New Zealand at a score of 350 across all bands within a 2 year period, a score of 300 in writing will be accepted after August, 2022 (Nursing Council of New Zealand, 2022).
<b>Overseas Registered Nurse (ORN)</b>	is a person who has undertaken a nursing qualification and is registered as a nurse in a country outside a host country (in this case New Zealand). Overseas Registered Nurse is used rather than Internationally Qualified Nurse (IQN) to differentiate this group from IQNs that are registered as a nurse in New Zealand. Other terms used in the literature are overseas educated nurse, foreign nurse and internationally educated nurse. The Ministry of Health (2020b) recognises the overseas nursing qualification as equal to the New Zealand Certificate in Health and Wellbeing (Level 3) for pay equity purposes for those with degrees or diplomas in nursing from the Philippines, India, South Africa, Australia and the United Kingdom.
<b>Participant Information Sheet (PIS)</b>	is the information provided to participants to provide written information about the research, including contact details of the researcher and supervisors. The information sheet enables an informed consent process.

**Registered Nurse (RN)** In New Zealand an RN is a person who has undertaken appropriate education and practice experience and has met the criteria to register with the Nursing Council of New Zealand. For an overseas registered nurse this includes successful completion of a CAP. An RN practices as a nurse independently or in collaboration with other health professionals. The RN is responsible for direction and delegation to others including health care assistants. There may be limits on the scope of practice of an RN depending on their education and experience (Nursing Council of New Zealand, n.d.-d).

**Tertiary Education** in this study refers to universities, institutes of technology and polytechnics who provide programmes of study in nursing and health at Level 7 and above on the New Zealand Qualifications Authority (NZQA) framework.

# Appendices

## Appendix A Ethics Approval



**AUTEK Secretariat**

Auckland University of Technology  
D-88, WU406 Level 4 WU Building City Campus  
T: +64 9 921 9999 ext. 8316  
E: [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz)  
[www.aut.ac.nz/researchethics](http://www.aut.ac.nz/researchethics)

9 April 2018  
Marion Jones  
Faculty of PVC - Research

Dear Marion

Re Ethics Application: **18/47 What influences the practice of overseas registered nurses who work as healthcare assistants in aged residential care in New Zealand**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEK).

Your ethics application has been approved for three years until 9 April 2021.

**Standard Conditions of Approval**


1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>.
3. Any amendments to the project must be approved by AUTEK prior to being implemented. Amendments can be requested using the EA2 form: <http://www.aut.ac.nz/researchethics>.
4. Any serious or unexpected adverse events must be reported to AUTEK Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEK Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEK grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz)

Yours sincerely,



Kate O'Connor  
Executive Manager  
Auckland University of Technology Ethics Committee

Cc: [debbie.coates@toihomai.ac.nz](mailto:debbie.coates@toihomai.ac.nz); Valerie Wright-St Clair

## Appendix B Toi Ohomai Ethics Approval

**TOI-OHOMAI**  
Institute of Technology

toiohoma.ac.nz | 0800 86 46 46 | info@toiohoma.ac.nz  
Rotorua | Tauranga | Taupō | Tokoroa | Whakatāne

16 May 2018

Debbie Cootes

Dear Debbie

Project title: What influences the practices of overseas registered nurses who work as health care assistants in aged residential care.

Thank you for submitting your student Research Proposal received on 18 April 2018.

The Toi Ohomai Research Committee notes your application and the ethics approval from your host institution. I am pleased to inform you that the above-mentioned project has been thoroughly reviewed and approval has also been granted by the committee on 10 May 2018.

A suggestion made by the committee was to think about asking the interviewees what they bring from their own culture that influences their practice in this country.

This application has been assigned a unique reference number – #18010. Please use this reference number when sending future correspondence to the Committee.

We wish you success in your research.

Kind regards,



**Dr Heather Hamerton**  
Chair  
Toi Ohomai Research Committee

## Appendix C Participant Information Sheet



### Participant Information Sheet

**Date Information Sheet Produced:**

28/01/2018

**Project Title**

What influences the practice of overseas registered nurses working as healthcare assistants in aged residential care in New Zealand?

**An Invitation**

My name is Debbie Coates. I am completing research as part of the Doctor of Health Science at AUT University.

I invite you as an overseas registered nurse working as a healthcare assistant in aged residential care to participate in this research study.

Please be aware that participation in this research will neither advantage nor disadvantage your application for visas or employment.

**What is the purpose of this research?**

The research aims to benefit overseas registered nurses by understanding what influences their practice when working as a healthcare assistant to be better able to support them in their transition to being a registered nurse in New Zealand.

I am undertaking this research as part of the Doctor of Health Science qualification at AUT University. The results may be published in national or international journals. The results may also be presented at conferences.

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

You have received this invitation after you responded to an advertisement about this study. You are eligible to participate if you

- Are an overseas registered nurse not yet registered with New Zealand Nursing Council
- Are currently working as a health care assistant in aged residential care in New Zealand
- Have worked as a health care assistant in aged residential care for at least six months.
- Are able to hold a conversation in English about your practice
- Have initiated New Zealand Nursing Council registration

You are excluded from this research if I know you already or you are studying on any programmes taught by me.

You may be excluded if there are too many applicants in which case those with the most experience as a health care assistant will be asked to participate

**How do I agree to participate in this research?**

You agree to participate by signing the consent form.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible. You are required to complete and sign a consent form prior to participation.

**What will happen in this research?**

The research involves you being interviewed by me for up to 1½ hours. You will be asked questions about your practice as a health care assistant as well as your culture and past experience as a Registered Nurse overseas.

You will also be invited to a group interview with other participants but you do not have to attend this group interview if you are not comfortable about joining a group. The group interview will also last up to 1½ hours.

**What are the discomforts and risks?**

You may feel a little discomfort talking about the things that influence your practice as a health care assistant but be assured there will be no consequences on your visa applications or employment possibilities.

**How will these discomforts and risks be alleviated?**

If you wish, you may bring a support person with you to the interview. This person will be required to sign a confidentiality agreement. Please let me know if you wish to do this prior to the interview.

If you feel any discomfort during the interview you do not have to answer the question. The interview may be stopped at any time.

If you feel any discomforts and require support Toi Ohomai Institute of Technology offer three free sessions of confidential counselling support for students. You can access these services via the Health and Wellness centres on Rotorua and Tauranga Campuses.

**What are the benefits?**

The benefits for you are that you will have an opportunity to talk about your practice and your contribution to caring for residents in aged care. Potentially you will be supporting future generations of overseas registered nurses in their transition to New Zealand.

The benefits for me are you will be helping me complete the research required for me to gain the qualification Doctor of Health Science. As I have been passionate about this topic for several years you will be helping me gain personal satisfaction being able to complete this research.

The wider community such as aged care facility managers, education providers, Nursing Council of New Zealand and Professional Bodies like New Zealand Nurses Organisation may benefit from this research. Knowledge and understanding of the practice of overseas registered nurses who work as health care assistants may help to provide appropriate training and support that will protect the overseas registered nurse and ultimately may improve the quality of care provided to older people in New Zealand.

**How will my privacy be protected?**

You will be asked to think of a different name (pseudonym) to be used throughout the study so that you cannot be identified. This pseudonym will also be used in the final thesis as well as publications or presentations resulting from this research. Your real name will only be known to me and this will be kept confidential by me.

Participants taking part in the focus group interview will be expected to maintain confidentiality within the group.

Focus group participants will be identified only by the ethnic group they belong to, such as Indian or Filipino in the final report or any subsequent publications or presentations.

Your place of work will not be identified at any stage of the research including the data collection, analysis and write up phase or the final report and subsequent publications or presentations.

**What are the costs of participating in this research?**

There are no direct costs to you for participating in this study. It will take approximately 3½ hours of your time.

The individual interview will take up 1½ hours, should you choose to attend the group interview this will also take up to 1½ hours. You will be asked to review written documentation of the interview to ensure accuracy and you will also be asked to review interpretations of your interview which should take about ½ an hour.

**What opportunity do I have to consider this invitation?**

Please consider this invitation and respond to me via email within 2 weeks of its receipt.

**Will I receive feedback on the results of this research?**

You will be sent a summary of the research results.

**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

Name : Professor Marion Jones.

Email: [marion.jones@aut.ac.nz](mailto:marion.jones@aut.ac.nz)

Phone: +64 21780808

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, Kate O'Connor,

Email: [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz) ,

Phone: +64 9 921 9999 ext 6038.

**Whom do I contact for further information about this research?**

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

**Researcher Contact Details:**

Name: Debbie Coates

Email: [Debbie.coates@toiohomai.ac.nz](mailto:Debbie.coates@toiohomai.ac.nz)

Phone: +64 7 5578792

**Project Supervisor Contact Details:**

Name: Professor Marion Jones.

Email: [marion.jones@aut.ac.nz](mailto:marion.jones@aut.ac.nz)

Phone: +64 21780808

Approved by the Auckland University of Technology Ethics Committee on 9<sup>th</sup> April 2018, AUTEK Reference number 18/47

## Appendix D Ethics Amendment



### Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology  
D-65, Private Bag 92006, Auckland 1142, NZ  
T: +64 9 921 9999 ext. 8316  
E: [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz)  
[www.aut.ac.nz/researchethics](http://www.aut.ac.nz/researchethics)

29 March 2019

Marion Jones  
Faculty of PVC - Research  
Dear Marion

Re: Ethics Application: **18/47 What influences the practice of overseas registered nurses who work as healthcare assistants in aged residential care in New Zealand**

Thank you for your request for approval of an amendment to your ethics application.

The amendment allowing participants to have a support person in attendance of the interviews is approved.

I remind you of the **Standard Conditions of Approval**.

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through <http://www.aut.ac.nz/research/researchethics>.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through <http://www.aut.ac.nz/research/researchethics>.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: <http://www.aut.ac.nz/research/researchethics>.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. If the research is undertaken outside New Zealand, you need to meet all locality legal and ethical obligations and requirements.

For any enquiries please contact [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz)

Yours sincerely,

Kate O'Connor  
Executive Manager  
Auckland University of Technology Ethics Committee

Cc: [debbie.coster@toihomai.ac.nz](mailto:debbie.coster@toihomai.ac.nz); Valerie Wright-St Clair



Are you an  
**OVERSEAS REGISTERED NURSE**  
working as  
**A HEALTH CARE ASSISTANT**  
in  
**AGED RESIDENTIAL CARE**  
for  
**6 MONTHS OR LONGER?**

If so, you may be eligible to participate in a research project that will enable you to talk confidentially about your practice

**For more information please email**  
**[Debbie.coates@toiohomai.ac.nz](mailto:Debbie.coates@toiohomai.ac.nz)**  
**Or phone 07 9218564**

## Appendix F Consent Form



### Consent Form – Individual and Focus Group Interviews

*Project title: What influences the practice of overseas registered nurses working as health care assistants in aged residential care in New Zealand?*

*Project Supervisor: Professor Marion Jones and Professor Valerie Wright-St Clair*

*Researcher: Debbie Coates*

- I have read and understood the information provided about this research project in the Information Sheet dated 28/1/2018
- I have had an opportunity to ask questions and to have them answered.
- I understand that I may have a support person present during the interview and that if I choose to do so, this person will be required to sign a confidentiality agreement
- I understand that notes will be taken during the individual interviews and that they will also be audio-taped and transcribed.
- I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.
- I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.
- I agree not to discuss any personal information about residents/patients
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- I agree to take part in this research.
- I wish to receive a summary of the research findings: (please tick one): Yes  No

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

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

Date:

*Approved by the Auckland University of Technology Ethics Committee on 9<sup>th</sup> April 2018. AUTEK Reference number 18/47*

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

## Appendix G Interview Questions

Can you tell me about an example of your nursing practice from your home country?

Can you tell me about a time you cared for an older person prior to coming to New Zealand?

Are there any differences in your practice as an HCA? Tell me about these?

Tell me about working in aged residential care from your perspective.

What helped you to get to know the residents?

What strengths do you bring to the role of HCA?

What are the main challenges for you working as a HCA in aged residential care?

What is the difference about working in a NZ workplace?

What is it like in this in this team of people? How is it different in this team?

Have you ever been tempted to do something you have done as a nurse previously?

How do you feel about your new role? Do you see any benefits of working in this role?

### **Probes**

- Tell me more? Can you give me an example of this?
- What does this mean to you?
- How do you feel about this?
- Why is this happening?
- What works well?

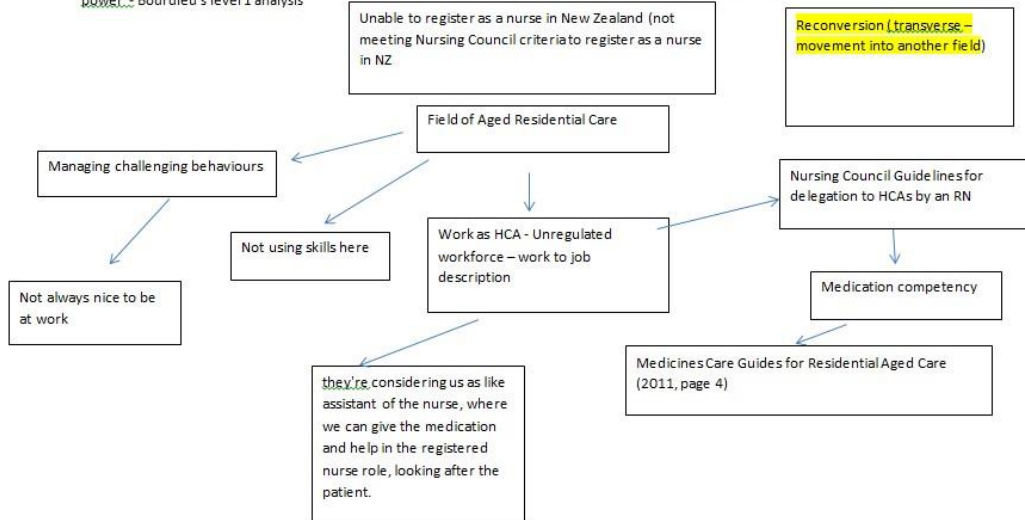
### **Checklist**

- Relationships with residents and work colleagues
- Language
- Challenges
- Different cultures

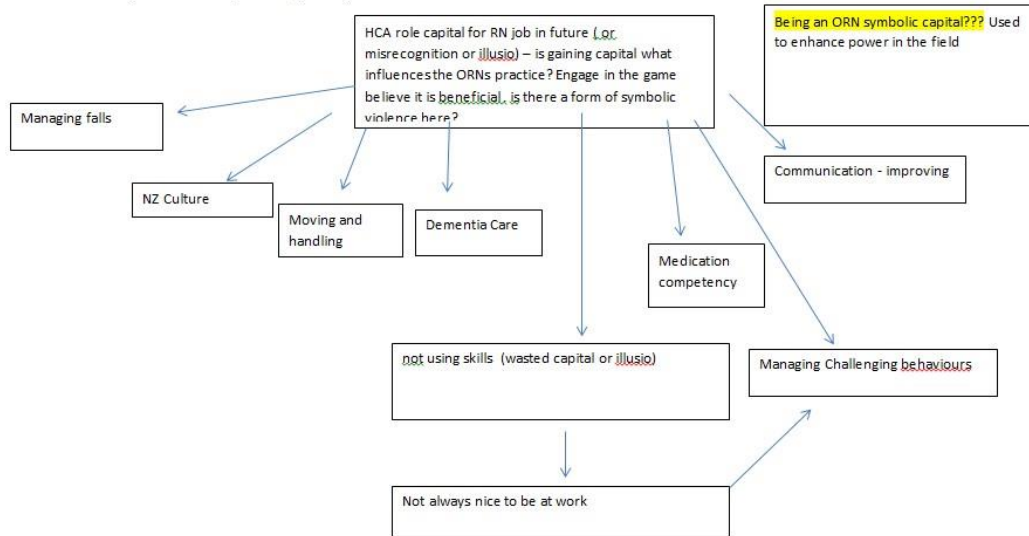
## Appendix H Mind Maps

Reviewing themes... Thematic Map – What influences the practice of overseas registered nurses working as HCAs in Aged Residential Care?

Consideration of the structures of nursing in New Zealand specifically in aged residential care (the field) in relation to the broader fields of power... Bourdieu's level 1 analysis



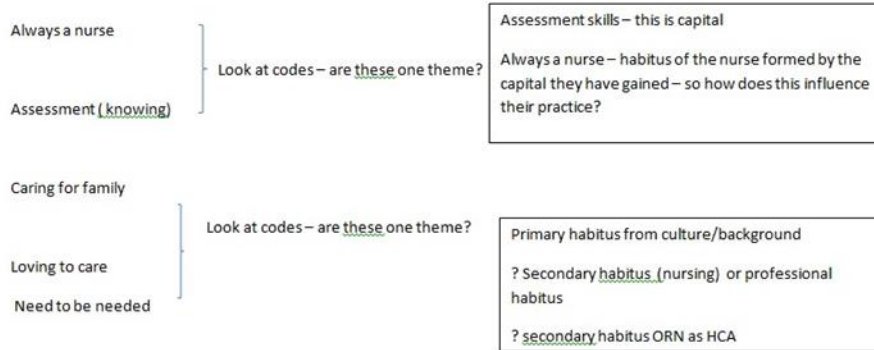
Bourdieu (1972/1977) level 2 analysis is consideration of the responses to the structures of agents (ORNs as HCAs) in the field (primary and secondary habitus and capital configuration).



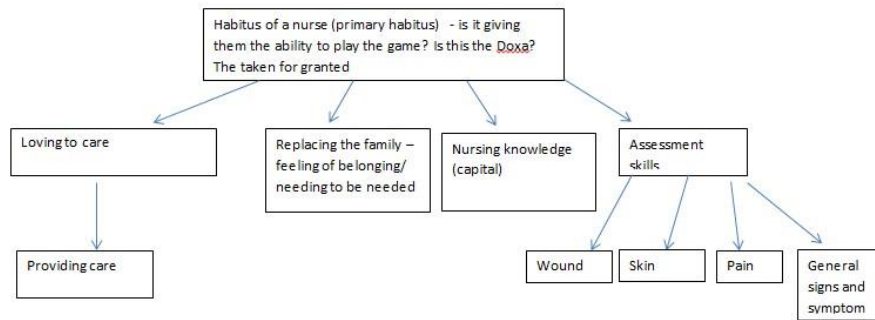
Bourdieu (1972/1977) level 2 analysis is consideration of the responses to the structures of agents (ORNs as HCAs) in the field (primary and secondary habitus and capital configuration)

Primary Habitus

Primary Habitus (what exists, bring to the role)



Level 3 analysis considers background, trajectory and positioning in the field in relation to the field past and present and the route to “fitting in”. Data related to habitus of agents were extracted



## Research Summary

### Project Title

*What influences the practice of overseas registered nurses (ORN) working as healthcare assistants (HCA) in aged residential care in New Zealand?*

### Thank you (name inserted)

*I am completing this research as part of the Doctor of Health Science at AUT University.*

*You participated as an overseas registered nurse working as a healthcare assistant in aged residential care and I wish to thank you for doing this.*

*As promised at the time of your interview I am now providing a summary of the research.*

### The research

*The research aims to benefit overseas registered nurses by understanding what influences their practice when working as a healthcare assistant to be better able to support them in their transition to being a registered nurse in New Zealand.*

*I interviewed eleven participants who are an ORN and met the criteria of the study. Eight participants are from India and three are from the Philippines. All participants had worked as an HCA for over 6 months at the time of the interviews.*

*The interviews were recorded and transcribed word for word using a professional transcriber. I listened to the recordings over and over and read the transcripts again and again. Using a thematic analysis framework I systematically analysed the transcripts to code data and cluster these codes into themes.*

*I used Bourdieu's theory of practice to interpret the data. Bourdieu's theory of practice considers the characteristics, dispositions and attributes a person has developed over time and how these influence the way a person acts and feels in certain situations. The theory also considers how the resource a person brings to a situation influences their action. These resources (Bourdieu calls capital) can be formal qualifications or knowledge and skills developed from living in certain societies.*

### The Findings

Three main themes which are evident in the data are:

1. **Finding a sense of belonging.** Some participants explained how fitting in was difficult at times as they tried to understand the HCA role and build relationships with staff and residents. For some participants there was tension between them and other HCAs who were not an overseas registered nurse but had been working in the facility for some time. This tension led to the participants feeling devalued and not fitting in. Some participants also struggled because residents preferred not to be cared for by them, this at times was perceived to be because of their race.
2. **Personal and professional habitus,** which is characteristics, dispositions and attributes from a person's background which influence practice. This included showing respect for older people, treating residents as if they are family and being able to build relationships which are crucial to be able to provide care. The data showed relationships with residents are also important for the participants at a time when they are apart from their own family. The data also showed that participants used assessment and decision making skills learnt and practiced as a registered nurse overseas which highlights a difference from an HCA who is not a qualified nurse.
3. **It was all worthwhile.** Participants acknowledge that the HCA role in aged residential care was not their dream job and was not where they wanted to be long-term. Participants discussed many nursing skills they were unable to use but also appreciated gaining new knowledge and skills whilst in the role, such as improving English and learning about Māori culture. The majority felt more like a nurse once they had completed the medication competency. This appeared to be a significant step towards feeling valued and finding a sense of belonging. Many of the participants felt the HCA role would help them in their future career as a nurse in New Zealand because it gave opportunity to become familiar with the NZ context and the aged residential care setting.

In conclusion the findings show the ORN is valuable to be able to provide good quality care, they bring many skills and attributes not recognised and more support should be available to help the transition of ORNs into the workforce in New Zealand.

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