Internationally Qualified Nurses' Perceptions of How the New Zealand Registered Nurse Competency Assessment Programme Enabled Transition to Clinical and Culturally Safe Nursing Practice in Aotearoa New Zealand

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Abbreviations Used

CAP	Competency Assessment Programme
HPCA	Health Practitioners Competence Assurance
IELTS	International English Language Testing System
ICN	International Council of Nurses
IQN	Internationally Qualified Nurse
IV	Intravenous
NCLEX	National Council Licensure Examination
NCNZ	Nursing Council of New Zealand
NZNO	New Zealand Nurses Organisation
NZRN	New Zealand Registered Nurse
OECD	Organisation for Economic Co-operation and Development
OET	Occupational English Test
OSCE	Objective Structured Clinical Exam
RN	Registered Nurse
TTMA	Trans-Tasman Mutual Recognition Act
UK	United Kingdom
USA	United States of America

Attestation of Authorship

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

Signed:

Date: 3 April 2022

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Abstract

Aotearoa New Zealand faces a workforce shortage of nurses nationally. One current approach to address the labour deficit is recruiting internationally qualified nurses (IQNs) into the workforce. Undertaking a competency assessment programme (CAP), entailing targeted study and clinical assessment, supports IQNs to meet Nursing Council of New Zealand requirements for nursing registration in Aotearoa. However, CAP providers offer the course with diverse approaches and there are no standardised curricula. Furthermore, to date, there is no empirical evidence on the utility of the CAP for IQNs regarding how well the programme meets its intended objectives from the perspective of the IQNs. This research aimed to identify the elements of the CAP that a specific cohort of IQNs found relevant and useful in their first two years of working as a registered nurse (RN) in Aotearoa. A secondary aim was to ascertain if, and how, the course was perceived to enhance their acculturation into the Aotearoa nursing profession.

A qualitative research method of focused ethnography framed the methodological approach. Semi-structured interviews occurred with purposive sampling of CAP graduated IQNs from the Philippines and India, representing the largest practising IQN groups nationally. Twelve participants—eight from the Philippines and four from India—with between 3 and 17 years working as RNs in Aotearoa, were recruited from the upper North Island of Aotearoa. Thematic analysis of the data resulted in two main themes describing the participants' experiences on the CAP: 1. navigating new professional practice and 2. the need for language proficiency and positive social support. Sub-themes arising were unfamiliarity with new clinical areas and nursing roles, feeling deskilled, and misunderstanding the healthcare concepts of cultural safety and te Tiriti O Waitangi. In addition, communication barriers, with English not being a native language, Aotearoa accents and new professional terminology, significantly influenced their experiences. Finally, novel research findings were the participants' new understandings of the symmetrical power balances between healthcare professionals in Aotearoa and recognition of the importance of the support gained from engaged and knowledgeable clinical preceptors.

This research found that the participants did not view their CAP experience as having a significant impact on learning new clinical skills, knowledge, or experience of their host country's nursing workplace. Additionally, the curricula were not seen to have provided substantial educational and clinical experience benefits regarding the Aotearoa cultural

context with the exception of specific cultural practices (Tikanga) and their application to nursing service provision for Māori. Recommendations from the research are for a comprehensive multiple stakeholder review of the current CAP curriculum, specifically regarding the clinical practice model used for recontextualising nursing practice and transitioning IQNs into the Aotearoa workforce, and the provision of targeted te Tiriti O Waitangi healthcare education: and the potential for new registration pathways in-keeping with recent global trends with a focus on key nursing knowledge examinations, and mandatory modules on Aotearoa cultural context. A further recommendation is – the inclusion of extended orientation periods and mandating a period of professional supervision for IQNs in post-registration employment period.

You will find as a general rule that the constitutions and the habits of a people follow the nature of the land where they live

Hippocrates

When in Rome, do as the Romans do

Saint Augustine

Chapter 1 Introduction

This research explores the perspectives of internationally qualified nurses (IQNs), [1]professionals who have received their nursing education and qualifications in countries outside the country to which they have migrated, who have obtained registration in Aotearoa New Zealand (hereafter referred to as Aotearoa) regarding how the current Registered Nurse Competency Assessment Programme (CAP) supported their subsequent transition and integration into the Aotearoa nursing workforce.

Nursing Workforce and International Migration in the Aotearoa Context

The literature has acknowledged a global shortage of nurses for some time now. Moreover, predictions are that this will continue well into the future (Catton, 2020; Jenkins & Huntington, 2016; Riden et al., 2013; Woodbridge & Bland, 2010). International nursing workforce deficits were first reported as arising from the health sector reforms in developed countries such as the United Kingdom (UK), the United States of America (USA), Australia, and Canada (International Council of Nurses, 2006). Explanations provided in the literature for this deficit are the decrease in the availability of nurse training in favour of service budgeting practices (Buchan & Calman, 2004; Spence et al., 2019). Other factors contributing to the shortage include global population demographic changes, particularly ageing populations. Statistical modelling shows a predicted increase in people aged 60 years and above from 900 million to 2 billion, resulting in a rise of 12–20% of the total world population by 2050 (World Health Organization [WHO], 2015) with a concurrent rise in complex chronic conditions and illnesses. In addition, recent reports show global increases in health disabilities, ranging from a sensory impairment, back and neck pain, falls, diabetes, arthritis, dementia, and depressive disorders (WHO, 2021). Therefore, all countries will face significant challenges in meeting the resulting health and social system demands for providing long term complex care across the life span (WHO, 2015).

A response to the increasing global demand for nurses has been international nurse migration, a well-established phenomenon. Factors affecting the moves of professionals from the country of origin to a host country are conceptualised as ‘push’ and ‘pull’ factors (Kline, 2003). These factors indicate the wish to experience better working conditions, remuneration, professional development, career advancements, and better life and

[1] Also referred to in the literature as foreign educated nurses (FEN), internationally educated nurses (IEN) and overseas educated nurses (OEN)

education opportunities for families (Cassie, 2017; Kingma, 2007; Stievano et al., 2017). The prospect of improved living and employment environments is a critical pull factor for many professionals looking to emigrate globally (Adobo et al., 2020). This prospect is further fuelled by opportunities to assist their families financially by sending remittances home and improving their knowledge educationally or using migration to bring the family with them to the host country (Callister, 2011). The International Council of Nurses (ICN) (2006) has contended that the global nursing workforce shortages are linked to associated push factors such as high attrition rates in home countries due to poor work environments, low work satisfaction, and inadequate pay. The ICN also stated that internal and external migration will continue to profoundly impact the nurse population in the global market.

Aotearoa's Workforce Need for IQNs

As with other developed countries, the expectation is that Aotearoa will continue to experience a shortage of nurses up to and including 2025 (Buchan et al., 2005; Nursing Council for New Zealand, 2020; Spence et al., 2019). For example, there are predicted increases in population projections through net migration and ageing over the next 10 years, bringing the total to approximately 5-6 million people (New Zealand Government, 2020). As a result, Aotearoa will need to substantially increase its nursing workforce to meet the resulting population's healthcare service requirements (Nursing Council of New Zealand [NCNZ], 2013, 2019); in particular, those arising from an increasingly ageing population. In addition, a projected increase of people identified as being disabled in Aotearoa will occur over the next 40 years (Ministry of Social Development, 2011).

Further, comorbidities are associated with accompanying high acuity levels of health needs, such as long-term diabetes, respiratory conditions, mental health issues, dementia, musculoskeletal problems, and obesity (Ministry of Health New Zealand, 2016). Therefore, any deficit in registered nurse (RN) numbers will drastically compromise the ability to meet the additional healthcare needs of the populace. Added to this, is the complication of an ageing nursing workforce, with half of the present RNs expected to retire by 2025 (NCNZ, 2013). These factors are seen to promote the shortfall of national nurse graduates, whereby Aotearoa will continue to need to target IQNs into its nursing numbers to meet staffing demands (NCNZ, 2020; Walker et al., 2012).

The percentage of IQNs in the Aotearoa workforce has increased in the past few years from 21% in 2010/2011 (NCNZ, 2011b) to the present 27% (NCNZ, 2020). Initially predicted for 2025, this target has already overtaken the percentage rise expected for 2020 (NCNZ, 2013,

2019). As a result, Aotearoa now has the largest quota of IQNs as measured by the Organisation for Economic Co-operation and Development (OECD) (NCNZ, 2020). Additionally, an equal number of New Zealand Registered Nurses (NZRNs) migrate to other countries, making Aotearoa the country with the highest inflow and outflow of health professionals (WHO, 2020). As of 2019, 60% of the nurses on the register for the nursing council in Aotearoa are estimated to have gained their initial registered nurse qualifications overseas (NCNZ, 2019). Approximately 40% of new RNs, registered in 2019-2020, originate from the Philippines. This number of registrations has increased by around 350 from the previous five years. In addition, new RN registrations were around 33% from India, which increased by approximately 600 from the same data statistics, making the Philippines and India the primary source of the migrant nursing workforce in Aotearoa (NCNZ, 2020).

Historically, these trends show a marked shift in the demographics of IQN source country for the past decade, with the number of incoming trained RNs from the UK initially declining to less than 100 per year from a previous 800, then rising again to 266 in 2020. In addition, nurses migrating from Australia previously maintained a level of 85-95 annually; and are now increasing by 10 per year, with 194 in 2020 (NC NZ, 2020).

Background to the Recruitment of IQNs in Aotearoa

Recruitment of IQNs began as a means to fill nursing vacancies resulting from the lack of qualified RNs available for employment in Aotearoa commencing around 2010 (Clendon, 2012). This shortage of qualified staff was partly due to the health reforms in the 1980s and 1990s, where budget cuts and restructuring made nursing an unattractive career option for many (Kaelin, 2011). As a consequence of the drop in morale and the effects of the reorganisation of nursing services, many RNs left their employment to try other more financially lucrative occupations or pursue a nursing career overseas (North, 2010). As a result of this loss of healthcare professionals, district health boards (DHBs) began to actively recruit nurses from developing countries, such as the Philippines and India (Walker et al., 2012).

In 2020, due to the global pandemic—COVID-19 SARS variant—many countries closed their borders and limited the movement of people throughout the world (Shaffer et al., 2020). In addition, the pandemic has required nursing staff to respond and deploy resources and manpower to react to the consequences of infection. For example, nurses are testing for viral load in the population, and carrying out healthcare management and planning of the effects of the illness to include hospitalisation. Many countries, previously reliant on

migrating nursing staff, have faced difficulties acquiring and registering nurses to fill their workforce (Buchan, 2020). Concurrently, due to the resultant health needs of their own population in the pandemic, many countries, such as the Philippines, have limited the export of nurses to work in other countries (Shaffer et al., 2021).

In consequence of the demand for nursing workforces, due to decreasing numbers in the workforce and the harmful effects of the global pandemic overall, Aotearoa currently faces a shortage of nurses that directly impacts public hospital recruitment, particularly in the aged care sector (Adams et al., 2020). Recognition that reliance on employing IQNs into the Aotearoa workforce as an ongoing requirement, with the expectation of ameliorating the current and predicted long term shortage of RNs in practice, has, therefore, been validated. It requires proactive planning to action (Gesmundo, 2016).

However, the requirements for IQNs to obtain registration in Aotearoa differs for each country's migrant nurses, and attendance on a RN Competency Assessment Programme (CAP) course is mandated for nurses from the Philippines and India. Therefore, the CAP course is the only nationally recognised pathway for IQNs from these countries to obtain registration in Aotearoa through accreditation with the NCNZ (2015a); and will be discussed in more detail in Chapter 2.

The CAP course provides a means of assessing the nursing knowledge application of its IQN candidates and assessing their clinical assessment and critical thinking skills. It provides evidence of how the candidates meet the required NCNZ nursing competencies. However, my liaison with CAP providers in Aotearoa has identified that the current CAP course is delivered differently by each provider; whilst still adhering to the required standards set out by the NCNZ (2008). Additionally, to date, there are no published studies that examine how well the CAP course prepares IQNs to work clinically and provide culturally safe care in the Aotearoa nursing context (NCNZ, 2015b). Whilst Aotearoa has become reliant on the recruitment of IQNs, there is a need to consider the requirements for registration as RNs in the Aotearoa New Zealand workforce.

Researcher's Connection and Positionality

I am an internationally qualified nurse who immigrated to Aotearoa in 2007 from the UK, having been a RN there for over 25 years. I did not have to undertake a CAP course to gain nursing registration in Aotearoa, as my original nursing qualifications were accepted following review by the NCNZ. Since my arrival into the new country and nursing role, I have personally managed my professional education and acculturation to meet my

interests and developmental needs for ongoing nurse registration. During this time, I have noted differences in the nursing culture and service provision I have observed compared to my home country, the UK. Additionally, as my first language is English, I did not (at the time of emigrating and looking for work) need to pass an English language qualification. I have since taught for over six years in a CAP course provided for IQNs to gain registration in Aotearoa and follow the NCNZ (2008) standards required for the provision of the course.

During my teaching and liaison with preceptors and other staff in the clinical environment provided for the CAP students, I noted communication and clinical assessment issues apparent with the IQNs now working as RNs in the facilities used for clinical placements. Having deemed these former CAP course students as competent, I was surprised to see that some of the nurses were not using their critical thinking skills or working as confidently as they presumably had been while supported and passing on their course. I began to wonder if this resulted from the CAP courses being too short to provide enough experience in the role of a RN in the Aotearoa context or being unsuitable for assessing their knowledge and skills. After reviewing the course curriculum and the length of the clinical practice component requirements from the NCNZ, I wondered if there was a need to revise or review the Council requirements. I then reviewed the pathway for obtaining acceptance onto the CAP course and pathway to nursing registration in Aotearoa. Finally, I wondered if the need to undertake a theory curriculum and clinical practice requirements were required to enable IQNs to gain more experience and knowledge to work in areas of which they were now confidently in charge.

I have become aware that my Scottish heritage and British nursing culture have influenced my workplace communication style and my expectations for nursing service provision. However, modifying my communication method to be less formal while still maintaining professionalism took me some years. As a result, my clinical nursing practice has not significantly changed. However, it has been modified by working with nurses whose ideas and procedures I have amalgamated into my own work style.

This recognition of the change in my nursing style led me to suppose that the nurses from the Philippines and India were experiencing similar issues adapting to Aotearoa nursing culture, but with the added complication of having English as a second language. International literature suggests that there were similar issues for IQNs in other countries and that each host country had produced differing recommendations for enhancing the processes of adaptation based on their findings. These reviews of the adaptation and

integration of IQNs resulted in changes in the initial registration processes for IQNs entering the host country workforces. For example, as discussed in Chapter 2, the UK and Australia have modified their initial registration processes for IQNs within the past few years. In this regard, Aotearoa has not kept up with its OECD counterparts, and the registration of IQNs continues to remain more complex. This complexity could negatively impact the recruitment process by affecting the number of IQNs applying to register in Aotearoa and the retention of these nurses in the workforce.

Aim and Research Questions

This research aimed to explore IQNs' perceptions of their experiences on CAP courses offered in Aotearoa. The following research questions were considered:

1. What differences (if any) in nursing practice were encountered between the CAP clinical placement experience and previous nursing experiences?
2. What clinical accountability and responsibility elements of the CAP were seen as applicable to practice?
3. How was the concept of cultural safety in nursing similar or different from previous experiences? How did this relate to understanding te Tiriti O Waitangi and its implementation in healthcare in Aotearoa?
4. What were other components seen as satisfactory or unsatisfactory from the CAP experience?
5. What implications can be drawn, and how can this be used to inform future IQN nursing registration processes in Aotearoa?

Methodology

A qualitative approach to address the research questions was deemed best to align with the need to hear participants' voices regarding their understandings of the CAP course curriculum and learnings about the Aotearoa healthcare system's specific cultural and societal contexts. In addition, the methodology supported the participants in describing how they dealt with the professional cultural expectations of clinical responsibilities, accountability for decision-making, and working with different cultural populations whilst on the CAP course.

Focused ethnography was employed to gain insight into the differences in nursing culture aspects and clinical care provision that the IQNs encountered whilst on the CAP course in Aotearoa. An important focus was the education and skills components that were

significant to the participants in preparation for working as RNs after entry to the Aotearoa nursing register. Furthermore, the methodology allowed identification of the specific elements the IQNs recalled from the CAP course that assisted their transition into the Aotearoa nursing workforce culture.

Content Structure of the Thesis

This thesis comprises nine chapters in total. The current chapter outlines the study with contextual information on the current process for IQNs to obtain nursing registration in Aotearoa, the researcher's connection to the topic, and how the research will address a gap in the literature. It concludes with a provision of the thesis structure.

Chapter 2: Contextual background for the research study

The second chapter compares four Western countries' processes—USA, UK, Australia, Aotearoa—for IQNs to obtain RN registration in the largest population destination countries for migrant nurses from Asia. Next, it outlines the origins of the current IQN registration process in Aotearoa. Finally, it defines the complexity differences in the different countries' processes and highlights current challenges to the IQN RN registration process in Aotearoa.

Chapter 3: Professional development and professional socialisation of nurses in three selected countries

The third chapter investigates the history of nursing and its current presentation as understood in three countries—the Philippines, India, and Aotearoa. It examines how these nursing professions evolved within separate cultures and highlights differences and similarities in their current nursing education and professional cultures. To support the research question of the significance of CAP course elements for IQNs, the need to examine the differences in the nursing service provision between the different cultures is identified. Finally, it compares and contrasts how the IQNs from the Philippines and India approach their role as RNs in Aotearoa.

Chapter 4: Acculturation, Cultural Shock, and Social Integration

This chapter provides an overview of acculturation concepts and theories. In addition, it examines the existing international literature on the processes involved with migrant nurse transition, such as culture shock and some of the known issues identified from previous studies. Furthermore, it examines the processes encountered by IQNs in acculturating to the Aotearoa nursing workforce. Finally, it presents some of the impacts of culture or

power distance as encountered by IQNs transitioning and acculturating to a host country's workforce.

Chapter 5: Literature Review

Chapter 5 explores the current international and local literature and research into the transition of IQNs into the host country's nursing profession. Critical analysis of the available literature is separated under the headings: IQN integration into new healthcare systems, socio-cultural barriers, and professional dissonance. Moreover, it details why the research findings are valuable and necessary in light of current global nurse shortages and recruitment needs. The review provides the identified gap in the literature regarding the significance and utility of the current CAP course in supporting IQN acculturation into the Aotearoa nursing workforce

Chapter 6: Research design, methodology, and method

This chapter outlines the reason for choosing the qualitative methodology used in the research study. It discusses how the methodology of focused ethnography fits with the researcher's epistemological and ontological position of the constructivist/interpretive paradigm. Additionally, it presents the research questions and overviews the anthropological and ethnographic methodologies used. Furthermore, it provides details of how the study was conducted by presenting the criteria for participant recruitment, the rationale for selecting participants, key demographics, and ethical considerations. Methods of data collection, approach to the interviews, theming analysis are described and discussed, as well as the rigour and validity of the research.

Chapter 7: Findings

This chapter presents categories and the main themes and sub themes from the data, and illustrative direct quotes from participants. The findings provide context for the participants' experiences and perceptions of whether the CAP course had enabled a successful transition into the Aotearoa clinical and cultural nursing practice. Two themes emerged from the data: a need for language proficiency and positive social support; and navigating new professional practice; with sub-themes around 'communication barriers', 'feeling deskilled and confused in the clinical practice area', and 'misunderstandings and merging of the concepts of cultural safety and te Tiriti O Waitangi.'

Chapter 8: Discussion

This chapter presents a critique of how the findings addressed the research questions and the comparison with international and national literature on the acculturation of IQNs into

a host country's workforce. First, it focuses on a social dissonance as an organising framework drawn from the theme of communication barriers, confusion around accent and pronunciation and professional communication issues. and how this may have affected the participants' transition through their acculturation cycle. Second, critiqued is a professional dissonance framed from the theme navigating new professional practice and highlighting why the participants may have felt deskilled and unsure about the role of an RN in Aotearoa. Furthermore, it elaborates on possible reasons for the participants' misunderstanding of the concepts of cultural safety in nursing and confusion of how this fits in with te Tiriti O Waitangi regarding healthcare provision in Aotearoa. Finally, evidence on how the participants considered their overall experience of undertaking the CAP course and its relevance to becoming an RN in Aotearoa is highlighted.

Chapter 9: Conclusion and recommendations

Finally, the study's strengths, limitations, and possible future research topics are presented.

The key finding is that the IQN participants from the Philippines and India felt that their experience on the CAP course did not provide significant learnings about the clinical and cultural expectations of working as a RN in Aotearoa. Additionally, the participants found they had to overcome socio-cultural barriers such as communication. However, novel information obtained regarding the most significant element of the CAP for the participants was the new understandings of the differences in a more symmetrical power balance between healthcare professionals and the support received from the preceptors, which has implications for ongoing professional support for IQNs in the Aotearoa nursing workforce. Recommendations grounded in the findings are outlined for translation into educational and clinical practice.

Chapter 2 Contextual Background for the Research Study

This chapter provides background context for the research population and nursing workforce registration requirements in host countries. Information about the processes for IQNs to obtain nurse registration in the largest population destination countries for migrant nurses are presented and discussed. First, the chapter outlines the mandatory preliminary legal identity checks required for the assessment for the registration application. It will then outline and discuss the comparisons of the complexity of the different processes. Finally, outlined, and critiqued will be the process in Aotearoa and a review of the challenges for IQNs undertaking the process here.

Comparison of IQN RN Registration Processes in the First Choice Migration Destination Country

Globally, there are clearly defined and mandated processes for IQNs to attain the ability to practice as registered nurses in the countries to which they migrate (National Council of State Boards of Nursing, 2020). These processes are comparable in Australia, the UK, the USA, and Aotearoa. Historically, all four countries have been the first choice for employment migration into the nursing profession in western countries. Migrant nurses have to prove their education, language skills, and practical experience in every country they want to work, in order to prove that they are competent and can work safely in the profession. As each country has a different method of assessing nursing credentials, coupled with competition for the speed of assessment methods and wage differentials, migrant nurses will choose the best option for their situation. Information about the registration processes for each country is displayed on websites maintained by the nursing registrar for that country (National Council of State Boards of Nursing, 2020; Nursing and Midwifery Board of Australia, 2021b; Nursing and Midwifery Council, 2020; NCNZ, 2021a). IQNs can research processes and costs and decide where to work based on the expected criteria and the financial outlay required for registration.

The growing recognition of the decline in RNs worldwide has transformed nurses' registration and national recruitment process in the past two decades (Buchan et al., 2018; Cooper et al., 2020; Valdez et al., 2021). Furthermore, the significant impact of health services management from the global pandemic due to the COVID-19 virus is now an extensive consideration in nurse recruitment and registration. In addition (as of 2020), the current COVID-19 related resulting restrictions to international travel and the high demand

for nurses in each home country affected by the virus have negatively impacted nurse migration patterns (Shaffer et al., 2021). These restrictions on nurse migration and workforce deficits have made nurse recruitment more complex. However, apart from Aotearoa, each country noted above has modified its application process to suit the profession's needs and recruitment methods based on its regulation board's general population health needs, nursing education, and registration requirements. The nursing council in Aotearoa has not responded to nursing recruitment needs by significantly modifying its IQN registration process for over 15 years and has not reported any immediate plans to review it.

In order to compare the difference in the registration processes for IQNs, this chapter will first outline the registration process in two selected countries with both historical and currently large numbers of a migrating nursing workforce, and then compare the registration process in Aotearoa. First, there will be an outline of the generic preliminary expectations for registration from each country to initiate their international nurse registration process. Next to be outlined, is the registration process in the USA and UK, the two predominant employers of Filipino nurses globally (Spurlock, 2020). In addition, the most recently modified processes of our nearest partner country, Australia, will be compared and contrasted with that of Aotearoa. Presentation of this process modification is essential for context and relevant to this research as the two countries have a shared agreement regarding nurse registration—the Trans-Tasman Mutual Recognition Act (TTMRA) 1997 (Ministry of Business, 1997). Finally, a discussion of the differences in requirements and time scales will support the rationale behind the undertaking of this research.

The research aim was to determine whether any CAP course components, as part of the Aotearoa IQN registration process, were most significant to the two predominant ethnic participant populations of IQNs; and, in particular, their registration and transition to working as a nurse in Aotearoa. Furthermore, the research questions focused on the participant IQNs' perspectives of the CAP course's cultural safety and Te Tiriti O Waitangi components. Additionally, questions about the clinical practice component related to the IQNs' perceptions of accountability and decision-making in the role as an RN were asked. The responses to these questions were identified to determine whether these parts of the CAP course were significant to their current role undertakings. Finally, the research questions asked the IQNs to share their most significant perceptions of the CAP course and how it subsequently supported them to practice as a RN in Aotearoa.

Preliminary Requirements for Application

The USA, UK, and Australia all require IQN applicants to meet similar evidential requirements to those of Aotearoa before applying for nurse registration (National Council of State Boards of Nursing, 2020; Nursing and Midwifery Board of Australia, 2021a; Nursing and Midwifery Council, 2020; NCNZ, 2015a). In addition, the UK and Australia's nursing regulatory bodies require the IQN to complete a self-assessment of their ability to meet the requirements prior to initialising the registration process (Nursing and Midwifery Council, 2020). In contrast, the USA uses a verification analysis company similar to Aotearoa to validate the IQNs' requirements; the CGFNS International Inc. Examples of evidence required by CGFNS on behalf of the nursing professional bodies are described in Table 1.

Table 1.

International nurse registration requirements globally

Proof of identity	Applicants must provide verified proof of identity in the form of notarised copies of two forms of identification, with one being a passport.
Language requirements	English communication must be at a designated required level. Evidence of meeting this requirement is attainment at a minimum score of 7 in all bands of the Cambridge International English Language Testing System (IELTS) and at least a B in all bands of the Occupational English Test (OET) relating to abilities in speaking, listening, writing, and reading English; taken within three years of application to register. (This does not, however, apply to applicants from Australia to Aotearoa under the TTMRA 1997. Additionally, some applicants may obtain a waiver based on prior nursing registration and education in the UK, Canada, Ireland, or the USA). However, in recognition of the difficulty of obtaining this internationally, the UK has dropped its English level requirements for writing to IELTS 6.5 (Nursing and Midwifery Council, 2020).
Fitness to practice	Applicants must provide an International Criminal History Check certificate and, if appropriate, a host country criminal history check.
Nursing professional educational requirements	Provision of evidence meeting the country's educational standards, which currently sit at the minimum of a Bachelor's degree level for all four countries.

Proof of nursing registration and experience	Applicants must hold a current nursing registration in their home country and have had a minimum of two years' work experience post-registration. Nurses from the Philippines must also provide an authenticated Board certificate for Aotearoa (Nursing Council of New Zealand, 2015a).
References	Professional references are required, and some countries require a two-year post-registration work history. However, the UK has recently amended its requirements for post-registration experience and will accept newly graduated IQNs into its assessment process.

Comparison of Three Preferred Host Country IQN RN Registration Processes

This section outlines the IQN registration processes in the USA, UK, and Australia. The three countries have different processes for IQNs after completing their assessment of the pre-requirements to apply for nurse registration. These processes range from a relatively straightforward application for assessment to a more complex one. The USA has the most straightforward process, consisting of competency assessment dependent upon the successful completion of an online exam. This process is valid for each American state, with the length of practical assessment dependent on their exclusive employment regulations (National Council of State Boards of Nursing, 2020). However, a sponsored offer of employment must now precede the application for registration. This visa requirement is not a requirement in the other countries but is encouraged in Australia and the UK (Nursing and Midwifery Board of Australia, 2021a; Nursing and Midwifery Council, 2021).

Both Australia and the UK have recently streamlined their IQN registration processes and have removed the requirement to complete a time-based clinical assessment period and replaced it with an Occupational Structured Clinical Exam (OSCE). However, the NCNZ still requires this period of assessment in clinical practice, which occurs via a specific course—the CAP (NCNZ, 2021a). In 2020, the Australian Nursing and Midwifery Board (AHPRA) changed the process for IQNs to obtain nursing registration and apply for work in Australia. Prior to this, the process was similar to the Aotearoa pathway, with an assessment of meeting specific criteria and the option of either enabling registration or necessitating completion of a 12-week education component known as the Bridging Programme (Aggar et al., 2020). The new, and now current, process was implemented to simplify assessing IQN registration and recruitment (Nursing and Midwifery Board of Australia, 2021a). The

previous assessment method consisting of the 3-month Bridging Programme, similar in content to the Aotearoa CAP course, was undertaken in educational facilities in Australia. The Bridging Programme assessed IQNs' education standards regarding nursing degrees obtained in their home country. Therefore, the programme provided evidence of equivalency in academic skill levels and an assessment of ability to meet the required competencies for the Australian nursing context. In addition to removing the Bridging Programme, AHPRA implemented a requirement for all IQNs to undertake a three-step orientation to the Australian culture, health service, and employer-based module when registering as a nurse.

Australia's Nursing and Midwifery Board has a list of countries identified as not having nursing degree programmes that meet the equivalency of the Australian nursing degree on its website (Nursing and Midwifery Board of Australia, 2021c). However, several countries meet the education and nursing context requirements, and no further assessment is required for IQN registration. Similarly, the UK and Aotearoa have identified that some countries other than Canada, Ireland, South Africa, and the USA have education and healthcare systems similar to those of their own. Therefore, IQNs from these countries have a shorter assessment process for IQN registration (Nursing and Midwifery Council, 2020; NCNZ, 2012). However, both the Australian and UK processes require online examination passes on nursing knowledge. In addition, Australia has an online cultural orientation module for completion regarding the Australian culture, followed by a second orientation module regarding the healthcare system (Nursing and Midwifery Board of Australia, 2021b). Finally, Australia expects the completion of an employer orientation programme following the nursing registration process. The UK process does not include a cultural orientation requirement at present. There is, however, a cultural safety and Te Tiriti O Waitangi component within the Aotearoa IQN registration process as part of the CAP course requirement.

IQN Registration Process in Aotearoa

Origins of the Process

The initiation of the pathway process for IQNs wishing to obtain Aotearoa nursing registration coincided with the passing, in 1992, of the TTMRA between Australia and Aotearoa (Ministry of Business, 1997). The TTMRA sets out a legal agreement regarding understanding between Australia and Aotearoa around equivalency of occupation registration status if the occupation is substantially similar to that of the other country.

Currently, compliance with the foundation regulations set out in the Health Practitioners Competence Assurance Act (HPCA) (Ministry of Health, 2003) forms the basis for the current process for registration criteria for IQNs. In addition to this is the need to meet the standards/requirements set by the NCNZ (2007) to obtain registration as a nurse in Aotearoa (NCNZ, 2015a).

The NCNZ manages applications for nursing registration from IQNs; however, there is no information published around the professional processes prior to 1996. Nevertheless, the information included in the following statement was obtained from an NCNZ long-serving member and is included for reference as to why the process changed. Following a request to NCNZ for information on the history of the IQN registration process (Appendix A), an email containing the agenda from an NCNZ meeting in 1999 was shared with me. It contains details of a reported receipt of fraudulent papers in submissions from Filipino applicants. This fraud led to NCNZ's need to manage such risks to the registration process. After this change, a decision was made to have a formal discussion with polytechnic nursing education staff at the time in order to formalise the IQN registration process in line with other countries' processes. A consultation paper was shared with CAP course providers, and the responses shaped the amendments leading to the current CAP course standards for curriculum requirements (NCNZ, 2008)

By 2008, the NCNZ had begun working with national polytechnics to begin developing national guidelines for programmes to assess the ability of overseas nurses and midwives to meet the newly designed NCNZ (2008) competencies. Suggestions included using the returning to practice course for New Zealand Registered Nurses (NZRNs) as a basis for the programme. Further consultation took place in 2012 to propose three possible pathways for nurses from other countries to obtain nursing registration in Aotearoa (NCNZ, 2012). In addition, there were suggestions for some inclusions in the course content around competency with communication skills, including assertiveness, leadership, and delegation, together with an acknowledgement of patients' rights and personal involvement in their care planning. Following the consultation submission and consequent ratification, the RN CAP was rolled out nationally as a requirement for IQNs to obtain registration in Aotearoa resulting in the processes outlined below.

In 2019, the NCNZ employed an external agency to verify IQN documentation authenticity, on their behalf, prior to the nursing council assessment of applications due to time constraints and consequent delays in processing applications (CGFNS International, 2021).

Following this change to the application requirements, the assessment of individual IQN applications became a three-step process (NCNZ, 2021a). The process begins with a separate fee-based application to an international document authentication and verification service—CGFNS International (2021)—on behalf of the NCNZ. All IQNs must complete this vetting process before applying to the nursing council for initial nursing registration and an annual practising certificate. Following the assessment completion and issuing a report to the IQN by the external agency (CGFNS), the second step is for the IQN to request that the assessment report be sent to the NCNZ. After receiving the report and assessing the information contained within it about the evidence verification, the NCNZ will decide whether or not to invite the IQN to complete the third step of the application process to NCNZ for nursing registration (NCNZ, 2021a). Finally, successful applicants will begin an assessment of their competency to practice by undertaking the process of completing a CAP course.

Assessment of Competency to Practice

Evidence of competency to practice is also required for the applicant to register as a nurse in Aotearoa. The NCNZ (2015a) has developed a 'Continuing Competence Framework' to ensure nurses are suitable for initial or renewal of registration. Assessment of the information provided by the IQN to support registration as a nurse must show details of clinical practice hours undertaken and any professional development educational hours attended. This hourly requirement must have occurred in the preceding two years prior to application and within the past five years of them working in a nursing role (NCNZ, 2021a). Alternatively, due to the different nursing roles and health contexts of Aotearoa, compared with many other countries (NCNZ, 2015a), attendance on and completion of a CAP course provided by an education facility approved by the NCNZ is acceptable (NCNZ, 2021a). Generally, the provision of a six to eight week CAP course includes nursing knowledge education and clinical skills components (NCNZ, 2008). In addition, the CAP course *must* contain education about the legal and ethical aspects of practising as a RN in Aotearoa, information on te Tiriti O Waitangi and its relation to health, cultural safety used in nursing service provision, and the use of and ability to work with current evidence-based clinical practice. The NCNZ stipulates that components of the CAP course require IQNs to be engaged in critical thinking processes, advocate for their patients, and have the confidence to challenge any practice that might be detrimental to patient care (Riden et al., 2013).

The CAP course also encompasses a practical assessment element and curriculum delivery on the Aotearoa nursing concept and related legislation. The clinical practice placement has no set time limit other than requiring completion within the 12 weeks of the course. Therefore, the supervised practice can be assessed as complete in as short as 2-3 weeks. The clinical component of the CAP course in Aotearoa is typically provided within the aged care clinical area, which can present problems for the IQNs. Nursing care provision in this clinical area has different meanings for IQNs, as discussed in Chapter 3. For example, there appear to be marked cultural and ethical differences in expectations on how nursing care provision occurs. In addition, IQNs' personal beliefs of providing active input for palliative and end of life care can contradict Aotearoa practices (Brunton & Cook, 2018). There have been times when the IQNs have been very scathing of the service provided to residents for comfort care instead of active treatment (Bland et al., 2011). Limited opportunities to use technical equipment such as Intravenous (IV) pumps and oxygen administration tanks occur due to a lack of need in residential facilities that refer and transfer residents to the hospital for higher levels of medical care as required. The focus on critical thinking and assessment skills require a basic understanding to register as a nurse at the level of RN2 for NCNZ (2015a), with an expectation that any further advancement in nursing competency levels will occur in their subsequent chosen job. Cultural safety for patient care provision is also expected and discussed on the CAP regarding its implementation when interacting with consumers of healthcare services as part of the Aotearoa nursing workforce.

Enrolment on a CAP course is time-limited and must take place within two years of the date of the letter of invitation. Together with details of a numerical allocation for the applicant, the letter also contains details of the conditions of assessed nursing scope of practice they can apply to meet on completion of the CAP (NCNZ, 2015a). In addition, once the IQN has successfully completed the CAP course nursing knowledge curricula and clinical competency components, the CAP course provider must prove to NCNZ that the applicant has met the required nursing competencies designated for RNs in Aotearoa. Finally, on completion of the above requirements, NCNZ invites the IQN to register as a nurse with a request that they pay the annual practising certificate fee relevant to the period regulated by the financial quarter of Aotearoa at the time of invitation.

Reported Challenges to IQN RN Registration in Aotearoa

A significant challenge are the financial requirements for an IQN to register as a nurse in Aotearoa. The costs for the application process are presented in several different currencies at different stages of the application process on the NCNZ (2021b) website and are non-refundable. Total financial output can reach upwards of NZ$15-20,000 per application as costs increase beyond the CAP course fees. For example, there may be further accommodation and subsistence costs if the IQN is not living near the education provider or clinical practice area provider. Furthermore, if the course provision occurs on a full-time basis, wages or salary income may not be received by applicants due to required attendance on the course. Moreover, in line with government advice, many clinical placement areas currently prohibit CAP students from external employment to the course as a prerequisite for attendance in their area due to the current risk of cross-infection from the COVID-19 virus (Ministry of Health, 2022).

Additional challenges are that the application process pathway, the period of the course length, and the overall application costs for nursing registration in Aotearoa are currently now more complex and expensive than those in Australia (approximately $5000 AUD), the UK (approximately 1300 GBP), and the USA ($1500 USD); the four preferred countries for nurse migration. In addition, IQNs require a good understanding of the English language and the possession of competent computer skills to access and undertake the CAP course and work in the Aotearoa nursing workforce.

Nurses from the Philippines and India are generally required to undertake the CAP course in Aotearoa as part of their registration process. It has been identified that their home country's nursing roles and healthcare context differ from those present in Aotearoa. Therefore, IQNs wishing to enter the Aotearoa nursing workforce will experience a significant transition to their experiences of working in a RN role (Brunton & Cook, 2018). Furthermore, it is acknowledged that they will meet different nursing concepts that will present challenges to their acculturation into the nursing workforce (Bland et al., 2011). These challenges present as culture shock (further described in Chapter 4). Therefore, an application to register in Aotearoa as an IQN must be a significant consideration for anyone wishing to begin the process and follow it to its conclusion.

Accordingly, a more detailed inspection of how the Philippines and Indian nursing education and nursing roles have evolved is required. Furthermore, an investigation into the educational and clinical differences will identify processes by which the NCNZ has made

informed decisions about the requirement for the extra steps in the application and assessment processes. The following chapter examines the development of the nursing profession in the Philippines, then India, and, finally, Aotearoa. This review will provide further contextual background for the current research study.

Chapter 3 Professional Development and Professional Socialisation of Nurses in Three Selected Countries

In order to contextualise the approach to this research, this chapter will briefly explore the evolution of nursing education and social culture impacting the current professional service provision (and, therefore, the nursing professional culture) in the nations of the Philippines and India. I will then compare and contrast the objectives of the RN role between the nurses in these countries and Aotearoa.

The Philippines

The Philippines is a country in the tropics consisting of over 7,000 islands, with three identified key island groups. Luzon, located in the northern area, contains the centre for businesses and governments in Manilla, where its nursing legal and professional regulations are created. The geographical location of the Philippines makes it a unique intersection between Asia and the more developed western worlds and has, therefore, made it a target for other countries wishing to control it (Jurado & Pacquiao, 2015). As a result, three key countries have influenced the shaping of the Philippines' cultures as they strove to control the gateway to Asia—China, Spain, and America. Following colonisation by the Spanish for over 300 years, and subsequently by the USA for almost 50, Filipino nursing professional culture has resulted as a combination of its first indigenous practices merged with those of its direct influencers (Rubio, 2019).

Before colonisation by the Spanish or Americans, the Philippines, like many other countries, had a culture of caring inherent to their communities with no formal label or record. For example, aboriginal healers would use local herb concoctions and spiritual physicians would say prayers when tending to sick members of the community (Ordonez & Gandeza, 2004). The first known record of a formal title of 'nurse' was used during the late 1500s when males called 'enfermero' assisted Spanish Friars when tending for the sick and wounded soldiers. Later, in the late 1890s, Filipina women assumed the nurse's role and joined the American Red Cross nursing teams as volunteers to combat tuberculosis and teach hygiene practices to the 'native' population (McCalmont, 1909). Following the Philippines subsequent involvement in Western and European politics through international commerce, the diversification of Filipino culture has led to exposure to many different people and cultures. However, Filipino nurses' indigenous values and cultures have amalgamated with colonial influences. Therefore, Filipino nurses historically exhibit a

stereotype of the caring professional with good professional training, yet a non-assertive attitude (Montayre et al., 2018).

A significant influence on Filipino nursing culture arises from introducing an education system stemming from the USA. Following the Spanish-American war in 1898, the United States government introduced nursing to unify the islands' inhabitants and introduce order to the newly conquered nation (Cassie, 2017; Vestal & Kautz, 2009). As a result, active recruitment of Filipino nurses to help with the United States' nursing shortages has occurred since the 1950s (Jurado & Pacquiao, 2015; Ortiga, 2014; Rubio, 2019). Initially, Filipina women were influenced to undertake nurse training by the perceived attractiveness of having an education and a profession, seeing nursing as a means to improve their country's progression.

Formal nurse training for Filipino women began in the early 1900s when the American missionaries and nurses arrived and noted a need to train the local women in hygiene practices to obtain assistance in the hospitals and community (McCalmont, 1909). There were no formal education requirements for these women, and the training occurred in the local Catholic hospitals. However, in the 1920s, laws were passed regulating nursing practice and the creation of a Board of Examiners for Nurses. Subsequent legal development of nursing training led to more professional and formal nursing education curricula. Finally, in the late 1940s, the first nursing degree, requiring secondary education for enrolment, was created in the Philippines following a review of the hospital training and finding it inadequate for public health nurses (Jurado & Pacquiao, 2015). Between the 1960s and 2000, there were over 500 nursing schools in the Philippines, with over 100,000 graduates per year (WHO 2014). However, further review into the quality and education provision of the bachelor's degree courses from these institutions in the early 2000s led to the closure of over 200 schools. More formal regulations and legal nursing practice Acts in the past decade have led to the enhancement of the experiences and qualifications of nursing education in the Philippines (Jurado & Pacquiao, 2015).

Currently, there is one unified national nursing degree curriculum in the Philippines, consisting of four years of study with registration set at international educational standards. The curriculum has two years of social science as its foundation and focuses more on the values and character of a person wishing to provide care to others (Rogado, 2005). As these tenets are emphasised and recognised as being valued in healthcare roles, it is easy to see why the stereotypical perception of cheerful, submissive, and caring nurses

are in demand globally (Montayre et al., 2018). A curriculum mix of competency-based and community-focused nursing is offered to prepare the graduates to be effective in any professional nursing setting. In addition, teaching in communication skills is undertaken in English to prepare the graduates to pass exams in national and international healthcare institutions. Social sciences are taught together with anthropology and health economics, and include philosophy, logic, and critical thinking (Rogado, 2005). Furthermore, the curriculum contains competencies relating to nursing concepts of legal, ethical, and moral principles; with an expectation that the graduate will provide safe, holistic care to all individuals from different populations, and will do this by collaborating with other healthcare professionals (Reblando, 2018). Currently, the Philippines nursing curriculum bachelor's degree programme occurs with American based teaching and textbook use (Ortiga, 2014; Vestal & Kautz, 2009). In his analysis of the Philippine nursing curriculum, Reblando (2018) identified its strengths as being compliant with international standards for core nursing competencies with the provision of essential skills in communication and leadership. Areas of identified weakness in the curriculum included a lack of robust community health education and research practicums. However, following the centralisation of the nursing regulations, the curriculum complies with international standards of nurse education (Reblando, 2018). It provides students with the ability to communicate adequately and form leadership skills for future employment and nursing specialisation as required internationally.

Conversely, a study undertaken in the Philippines by Ortiga in 2014 examined how a globally competitive nursing workforce requirement has validated the increased provision of nursing programmes to provide the number of nurses required overseas. Its findings showed that the process of imparting the information and knowledge about nursing to individuals appears to have suffered from the attempt to train large numbers of students in each class. Nurse educators approached in the study (Ortiga, 2014) stated they felt concerned that the nursing curricula had to be frequently modified to keep up with the international nursing standards. Among these changes reported was the requirement of adding a more significant portion of theory than clinical practice components. The programmes also had to cater to many nursing students while facing constrained resource conditions and impossible workload expectations. Having large classes and constantly adjusting curricula appears to have undermined nursing education to the extent that Filipino nurse educators feel the graduates have more academic than professional experience and values. A study by Ko and Thiel (2017) found that Filipino educated nurses

in the USA have positive attitudes to evidence-based practice and its use, but do not apply this at a practical level. Suggestions of the nurses being more focused on the tasks in their role than the clinical reasoning behind it were posited (Ko & Thiel, 2017).

The centralisation of professional regulation of nursing, combined with the large numbers of nurses graduating, led to the then President of the Philippines encouraging nurses to migrate to other countries, including the USA, to bring financial support back to the country (Jurado & Pacquiao, 2015). Later on, the draw of immigration to the USA as a means of increased earning and provision of visas saw a mass migration of Filipino nurses to the country, which continues today (Lanyon, 2020). Supporting the influx of nurses to the USA was the commencement of the USA-based nursing curriculum and the hope of better economic and educational opportunities (Jurado & Pacquiao, 2015). Underpinning this are the reported historical exodus of millions of Filipino nurses to the USA and Canada between 1999 and 2008 (Livelo et al., 2018; Siar, 2011). Aotearoa, too, has historically drawn heavily on the recruitment of Filipino nurses. For example, the introduction of neoliberal reforms in the Aotearoa welfare system, from the early 1990s, combined with the opening up of industry to competition from Asian capital and skill base, prompted a change in immigration policies to attract more nurses from Asian countries like the Philippines (Livelo et al., 2018). Finally, the continuing increase in nurse migration from the Philippines to western countries indicates that the Philippine government still regards its nurses as a global export commodity for overseas markets (Masselink & Lee, 2010; WHO, 2020).

There are two notable influences on the Filipino nursing culture described in the literature. The first influence identified is the provision of respectful and reverent care, derived from the spiritual values of the Catholic religion introduced firstly by the Spanish rule and laterally the American Red Cross nurses who entered the country following the Spanish-American War (McCalmont, 1909). Common descriptors of the Filipino nurse in literature are that of a caring and compassionate, patient, and happy professional (Ordonez & Gandeza, 2004; Rubio, 2019). Many studies focused on the attitudes and behaviours of Filipino nurses give similar descriptions of well trained and highly valued individuals who provide genuine and patient-centred care (Ea et al., 2010; Jurado & Pacquiao, 2015; Livelo et al., 2018; Rubio, 2019). Other positive traits are a good work ethic and the ability to adapt quickly to new situations (Lanyon, 2020).

In contrast, due to a high regard for their elder members of society and those seen as having authoritative positions, Filipino nurses can be seen as being too passive and

reluctant to express opinions in communication (Ordonez & Gandeza, 2004). Use of questions in place of giving directions; for example, asking staff to change medications with the use of "Would you like to?" rather than "Please do…?" is often seen as a limitation in healthcare workplaces (Cherry & Lucas, 2017). In addition, non-confrontational behaviour and conflict-averse attitudes described in the literature are regarded as a limitation of Filipino nurses' professional work (Vilog et al., 2020). Daniel et al. (2001), described how Filipino nurses will follow doctors' written orders to the letter and are more used to the hierarchical status difference. Similarly, there is an identification of observed subservience to medical staff noted in many nursing research studies (Connor, 2016; Nortvedt et al., 2020; Rubio, 2019).

In some cases, the tendency to be subservient to medical staff is a trait that is difficult to overcome. The literature contends that Filipina female nurses' descriptions of being shy and timid are common (Ea et al., 2010; Vestal & Kautz, 2009). The consequences are that they can also give the impression of not being in authority and not making decisions when required. Although understood as being respectful and sensitive of others' feelings in the Filipino culture, it can lead to the perception that the nurse cannot ask questions or challenge someone if there is an issue requiring discussion. Advocacy on behalf of patients can, therefore, be limited. Modesty in receiving accolades for work undertaken may also be a limiting factor, and the plural 'we' when discussing task completion is often mistaken for single contributions in work. Using a third collective pronoun instead of 'he' or 'she' frequently leads to communication issues with nursing documentation, as Western cultures deem the written notes incorrect if the wrong pronoun is used (Vestal & Kautz, 2009).

Filipino social culture is also defined as being more collectivist in nature, focusing on the interdependence of the group rather than on the individual within the group (Broomhall & Phillips, 2020). Collectivism emphasises the importance of group cooperation and interests resulting in the harmony of the community in which it sits (Xu & He, 2012). This attitude can manifest as a willingness to prioritise the group's goals above the persons' individual goals. The nursing culture may present with the Filipino nurses having different attitudes and behaviours toward their roles and expectations than Western nurses and of carrying out tasks they have been given rather than critically thinking about what the patient needs (Liou et al., 2013). Based on these differences in professional behaviour, the reluctance of Filipino nurses to question authority can be more easily understood.

It is critical, then, to understand how the influence of the underlying social culture and the method of nurse education led to the perception of the stereotypical 'Filipino nurse' as subservient, lacking communication skills, less autonomous; yet caring and hard-working (Ordonez & Gandeza, 2004). The impact of the perception influences how the Filipino nurses are supported to migrate into a host nation's workforce and the means by which they must obtain registration. Furthermore, continued perceptions of passive, task-focused work of Filipino nurses (Ko & Thiel, 2017) will support the current expectation for a lengthy competency course in Aotearoa. Awareness of the knowledge about the social and nursing culture in the Philippines is, therefore, critical in framing policies and guidelines to support Filipino nurses' integration into the professional nursing workforce.

India

Like the Philippines, the Indian nursing culture has been influenced by long-standing cultural norms, subsequent colonisation, and change to its education systems. Before colonisation by the British, nursing in India evolved from the practice of Ayurveda. Documents that detailed medical and surgical practices for people and referred directly to nursing the sick, align with the notes written to detail the specific expectations of a nurse caring for a patient (Somjee, 1991). Following a resurgence in Hinduism in AD300, conformity to social norms and hierarchy led to the formation of a caste system which led to the identification of socially acceptable practices such as what could be touched or eaten and by whom. The nursing service in India subsequently suffered from demarcation as to what was permissible care provision for specific castes, limiting the previous all-inclusive care provision. India was then the victim of several invasions and social changes that had no marked effect on the uplifting of the profession of nursing. The European trade wars in the 17th century and the resultant need for military medical care led the British to open up centres and hospitals in the ports around India. Nursing sisters sent from Britain in 1905 established a training school under Christian missionary ethics. Thus, the beginning of a formal nursing service began (Jayapal & Arulappan, 2020).

However, the concept of nursing service provision was deemed unrespectable for anyone other than lower caste groups in India. Aspects of the caste system in Indian society caused status problems in nursing, determining concepts of hierarchy already deep-rooted in Indian society (Simon, 2009). As the main tasks revolved around washing and dressing the patients, the perception of it being dirty and degrading work carried on until the mid-19th century (Gill, 2018; Healey, 2010). The context of what comprised nursing duties supported

the perception that nursing was low-status work. Nursing students, therefore, emerged from very low-status, formerly low-caste communities of Christian converts. Many of these students migrated from Kerala to work as nurses in the hospitals, and most of them were Christians. Although other religions also generated nursing students, the class system ruled the choice of profession for many (Simon, 2009). Having close contact with unfamiliar male patients and other workers of the hospital meant that the setting was not seen as conducive for anyone wishing to be identified as a 'good' woman from a 'good' family. Traditionally, women in India were not allowed to speak in front of male relatives or strangers, and there was a view of women being incapable of independent life without male supervision (Nandi, 1977). There is still a reported patriarchal hierarchy within hospitals with continued class differentiation between nurses, patients, and doctors. Nursing in India remains strongly influenced by gender, class, caste, and religious components, impacting the profession (Jayapal & Arulappan, 2020). Expectations for nurses that they should be submissive and carry out doctors' orders without question remain (Gill, 2018). Furthermore, female nurses are still reported to be restricted in decision-making and authority and are not empowered to influence the health of their patients. Delegation of clinical responsibility for care activities in complex health issues is not handed from doctor to nurse, thereby limiting the ability to provide nursing care to patients (Nandi, 1977).

Although nursing as a profession in India remains a predominantly female workforce and corresponding studies show that it retains a lower social status (Gill, 2018); in recent times, more women are taking it up as a career to improve their status (Mawar et al., 2021). Familial support and encouragement have led to nursing recruitment becoming more socially sanctioned (Johnson et al., 2014). Having a vocational degree that provides a good salary is a better prospect for many from lower economic positions. The vision of possible world travel with the nursing qualification is a constructive pathway for social and economic betterment for many Indian families (Johnson et al., 2014). Migration and sending home remittance is another incentive for undertaking nurse training. Many nurses wish to travel and work abroad, and then return with knowledge and experience to share with their home country. Marriage prospects are also increased due to social status, as the modification of traditional dowry payment expectations now can include assets such as nursing qualifications (Walton-Roberts et al., 2017). Lessening cultural obligations and traditions give nursing a higher status professionally and support the attractiveness of nursing education for Indian women from all social collectives. Increased nursing recruitment has offered women more economic and social opportunities in India.

Combined with the opportunity of migration, this opportunity has been a critical factor in changing the image of nursing (Johnson et al., 2014).

The nursing education in India has similarities to that of the Philippines and Aotearoa in that it includes a degree level qualification. The Indian government, like the government in the Philippines, supports the export of nurses (Nair & Healey, 2006). The rapid growth of nursing schools in India has led to many nurses achieving internationally accredited levels of nursing education in the profession. However, there is an issue that some schools offer lesser qualifications at the diploma level, which may not be an acceptable education standard for registration in some countries (Gill, 2018; Kharde, 2012). As a result, most migrating nurses from India have achieved degree level educational qualifications with a generalist nursing outlook. The nursing degree is 50% clinical and 50% theory-based and includes areas of nursing in paediatrics and obstetrics. The language used in the nursing education theory sessions is English (Kelly & Fowler, 2019), with a more formal base. It, therefore, differs from spoken language and has less focus on everyday uses, such as discussions with patients and their families (Stubbs, 2017). It is also limited to use in classroom situations and not commonly used in day-to-day conversation; thus, restricting the practice of its use. In addition, there can be minimal academic writing structure and rationalisation of nursing interventions in Indian nursing degrees, which limits the ability to undertake this component when completing courses in the host country (Kelly & Fowler, 2019; Stubbs, 2017; Teasdale, 2005).

Other noted limitations of the degree qualification in India, compared to those in the western educational facilities such as the UK, Australia, and Aotearoa, are a lack of formal research training (Mawar et al., 2021). This deficit in academic learning can impact the awareness and use of evidence-based practice. The absence of research-based learning leads to a resulting lack of change in practice and understanding why and how to change it (Vijayalakshmi et al., 2014). In addition, the teaching method is primarily teacher-led and comprises rote learning of subjects until a sound theory of knowledge is achieved (Teasdale, 2005). Historically, the perception of the tutor as highly respected and almost god-like has its origins in the social standing and hierarchy of teachers from colonial times (Basuray, 1997). Teachers in nursing education in India began with British nurses and missionaries who chose selected civil servants and locals to support them to care for the British soldiers. These teachers demanded respect, and the Indian locals became revered due to their ability to purvey information to support spiritual and educational knowledge for the community. A level of authority from teachers in nursing, combined with increased

health outcomes for the community, enhanced these perceptions and continue to this day, as illustrated in the reluctance to question leaders in the workplace (Gill, 2018).

The combination of cultural influences from India's collectivist social structure and lack of knowledge in evidence-based nursing gives rise to the presented general stereotype of the 'Indian nurse' as being similar to that of the generic stereotype description of the 'Filipino nurse'. Increasingly, views of perceived subservience and lack of autonomy in their clinical work are due to the nurses themselves reflecting their experience of their training and working in their home country. However, the subservience perception is more apparent with Indian nurses in the Aotearoa nursing workforce, with Filipino nurses reported to have the ability to modify their behaviour in a shorter time (Walker et al., 2012).

Like that of the Philippines, a culture of migration is now evident in Indian nursing ambition, with many migrating to Aotearoa (Tsai, 2020; Walton-Roberts et al., 2017; WHO, 2017). The Indian nursing curriculum has shifted to a more globally accepted programme, with the highest nursing qualification being a four-year degree. Partnerships with Canada, the USA, UK, Australia, and Aotearoa have facilitated this migration of nurses and offered permanent settlement opportunities. Currently, many nurses travel abroad after obtaining their qualifications (Sharma et al., 2021). Indian nurses are more likely to see Aotearoa as their destination due to the geographical closeness to India and the similarity in generalist nursing qualification.

Aotearoa, New Zealand

As with the Philippines and India, more formalised nursing practices began in Aotearoa to answer colonial requirements for caregivers for their people. In the early 19th century, European settlers arrived in Aotearoa and brought different social and religious practices and diseases. Prior to this, many women were referred to as nurses if they assisted the sick or women in childbirth (Papps & Kilpatrick, 2002). The rise in the number of colonists exposed both the indigenous and colonial populations to more illness and a need for specialised medical care. Hospitals were established, and nurses were 'sent for' from Britain to deliver effective care for people. These nurses brought Christian values of compassion, cleanliness, and reverence of God (McKillop, 2013). Nurse training schools began to emerge, and the recruitment of educated women of propriety commenced.

Nursing education, however, was limited to 'European' women; and the passing of the New Zealand Nurses' Registration Act in 1901, although intending to legislate towards a more professional standing, deliberately excluded Māori women's eligibility (McKillop, 2013).

The Eurocentric influence on nurse education, derived from the practices of Florence Nightingale (1860) dictated that a nurse must meet the criteria of being 'dedicated' and having 'moral respectability'. Most valued were the attributes of patience, tact, being gentle, having attention to detail, observational skills, trustworthiness, and showing compassion and thought for their patients. However, Māori women were not viewed as having these traits at the time. Later, some Māori nurses were allowed to work under the supervision of their European counterparts until they had gained experience and been proven able to take charge in their home districts (McKillop, 2013).

Differences in social and traditional practices between the Māori and settler populations were not well understood. However, the implementation of the main concepts of European nursing *only* was introduced to restrict the spread of disease. Māori cultural practices were seen to be primitive and in need of change to improve their health status. European nurses provided education based on the principles of health care they had learned in nursing school. However, there was a need to evolve the traditional role of the European nurse as there was limited availability of doctors to manage serious illness and accidents in rural areas (Durie, 1988). Alongside this was an acknowledgement of a need to provide health services for Māori and community services from indigenous women providing nursing services to their 'own' people. Misalignment of health care responses regarding improving the health status of Māori led to an examination of how the nursing service was delivered to the two different populations—Māori and European. Māori nurses recognised that acknowledgement of the different cultures and an adaptation to service provision to support better care to Māori was required (Papps & Ramsden, 1996).

These developments outlined above led to the introduction of cultural safety into nursing education in 1992 by the NCNZ (2011a; Richardson, 2004). Cultural safety in nursing relates to the differing power balances in interactions between nurses and patients (NCNZ, 2011a). The desired outcome is a partnership of identifying and discussing any health discrepancies with the patient so that a supportive model of managing health issues is achieved whilst acknowledging the patient's wish to follow their self-identified cultural health practices. The ensuing partnership model of nursing has led to the view of empowerment for the patient and is markedly different from the earlier understandings of the nurse being in control of the situation, and is included in nursing education nationally (NCNZ, 2021c).

Current nursing education in Aotearoa can be via completion of a three-year degree with a subsequent year for supported practice (NCNZ, 2015a) or through completion of a two year

pre-registration graduate-entry master's degree and subsequent completion of components of the nursing degree. The expectations laid out by the New Zealand Nurses Organisation (NZNO, 2012) in their definition of professional nursing practice, state that the nurse defines their professional practice through culturally safe practice. It further states that the discipline is based on education and regulation that encourages and supports evidence-based practice underpinned by nursing theory and research. Collaboration with others to address health needs and the use of knowledge and skills to underpin this practice is based on the ability to have discourse with both patients and health care providers to contribute to positive health care outcomes. Aotearoa trained nurses are expected to be advocates for their patients and to have the ability to question proposed patient treatments and doctors' orders. Provision of safe and competent nursing care is the principle tenet of the nursing registration and is visible in all the nursing council competencies (NCNZ, 2007). Students are taught adherence to the patients' 'Code of Rights' (Ministry of Health, 1994) from the first unit of the degree and throughout the course. These points have led to nurse training in Aotearoa focusing on the encouragement of a more self-assured outlook on the nursing role and for the nurses to be more assertive and proactive around care provision.

Unlike the collectivist cultures of both India and the Philippines, Aotearoa presents with a more Western individualistic social culture. A definition of the essential difference between collectivist and individualist cultures is the concepts of 'self' and how this relates to a person or community (Caldwell-Harris & Aycicegi, 2006). Autonomy and personal rights are emphasised more in individualistic cultures, with preferences and needs of the individual prioritised more than those of the group (Xu & He, 2012). Individualist culture is evident in the Aotearoa culture and that of the nursing workforce, emphasising patient rights and the critical thinking, independent decision-making nursing ideology expected in its nursing education (NCNZ, 2021c).

Professional Observations of Socio-professional Cultures in the Tertiary Sector

Reflections on my nurse educator role in the classroom have provided examples of social interactions in the professional area of clinical workplaces and classroom areas with nurses from the Philippines and India compared with nursing students in Aotearoa. Notably, there has been a difference in how both nursing cultures have affected students' behaviour in the classroom sessions. For example, some behaviour descriptions of the stereotypical 'Filipino' nurse, as described in the literature (Ko & Thiel, 2017; Ordonez & Gandeza, 2004), have

manifested. Examples would be the deference given to me as the senior nurse (teacher) in the classroom and how the nurses will stand to attention in my presence. Lack of questions in the classroom also fits with the previously discussed perception of their inability to make decisions and lack of communication skills (Vilog et al., 2020).

However, awareness and support of the knowledge and skill base of the IQN throughout the CAP course have enabled a quick disappearance of the subservient nurse attitude. Equally, experiences working with nurses from India have provided me with insights into the hierarchy of the nursing system in India (Gill, 2018); for example, recognition of reluctance to question things in the classroom or a public situation, and observation of the nurses' answering "yes" to questions, whether they understood them or not. Unfortunately, this hierarchical view of the teacher as the most important person (Simon, 2009) occasionally continues to the end of the course, with a reluctance for IQNs to approach me for references for new job applications. In contrast, Aotearoa nursing students appear more confident in class and will approach me as their teacher more assertively. In addition, they appear more willing to challenge other teachers and me in class and question their preceptors and medical colleagues while on clinical placement. As shown in this chapter, the differences in the historical evolution of culture in each country impact the professional workforce and personal socialisation of IQNs in their destination countries.

Summary

Examining the differences in nursing education between the three countries, as discussed in this chapter, is intended to provide context for how nurses from the Philippines and India initially perceive their roles as registered nurses in Aotearoa. In addition, the CAP course purports to provide a bridge to transition into the nursing workforce (NCNZ, 2008). Therefore, examining the nature and content of the CAP course in supporting IQNs to acculturate to the new nursing service provision experience is paramount to this research. The following chapter outlines acculturation theories regarding professional workforce integration into a destination society, how this may occur for migrant nurses entering host country workforces, and, specifically, IQNs entering the Aotearoa nursing workforce.

Chapter 4 Acculturation, Cultural Shock, and Social Integration

The previous chapter offered an overview of the similarities and differences in the development of nursing education and the professional culture of nursing in the Philippines, India, and Aotearoa. Additionally, it presented context for the complex transitions needed both culturally and professionally in host countries. As Aotearoa has specific objectives for nursing service provision, patient safety, and optimal health outcomes (NZNO, 2012), IQNs are mandated to transition legally, ethically, and professionally to these expectations. In addition, there is an implicit expectation that IQNs become familiar with the country's bicultural partnership and apply its principles to their nursing in a short amount of time (Skaria et al., 2019). However, there is mounting evidence of a historical lack of targeted support to meet these objectives during orientation periods (Walker & Clendon, 2012).

The current CAP course provides a designated pathway to nursing registration for nurses from the Philippines and India (NCNZ, 2015a). However, as outlined in Chapter 2, each CAP provider's curricula pertaining to nursing knowledge content differs. In addition, the clinical practice component also differs nationally, with placements offered in hospital settings or aged care facilities. Although meeting the four standards required by NCNZ—content on Te Tiriti O Waitangi in healthcare, cultural safety in nursing, legislation for nurses in Aotearoa, and clinical skill update—there are no set requirements for implementation other than meeting the timeframe of 6-8 weeks. Thus, the CAP course offers limited beginnings to understanding the requirements of working as a nurse in Aotearoa; thereby initiating the transition or acculturation into the nursing culture.

Culture can be described as the mechanism of a social system and subconscious control of individuals' perceptions of their environment (Nishimura et al., 2008). Acculturation begins when incoming groups with different cultural backgrounds engage with the host group to integrate into an evolving social or professional interaction (Shafaei et al., 2016). It can be further defined as an intricate and complicated process occurring continually over time. It presents uncertainties for, and challenges to, the groups' innate beliefs, values, and expectations.

However, the question of how long it takes for a migrant nurse to acculturate into a host country's professional nursing culture has long been debated (Buscemi, 2011; Choi et al.,

2019; Goh & Lopez, 2016), and several concepts and theories have been posited. Therefore, this chapter will present an overview of the main concepts of cultural shock, acculturation processes, and culture distance; and critique the application of these concepts to the IQNs undertaking the CAP course to work as RNs in Aotearoa. Furthermore, to underpin and support the premise for this research, a review of the theory around the acculturation of nurses' transitions into new host country settings will inform the discussion. Finally, outlined is familiarisation to key aspects of transition encountered by IQNs during their adjustment period into the host country's workforce, regarding the CAP course in Aotearoa for IQNs seeking nursing registration.

Acculturation

Acculturation is a concept in anthropology and sociology originating in the early 20th century. It explains how people adapt and modify traits from diverse cultural backgrounds when in prolonged contact to make changes in one or both groups (Berry, 2005; Buscemi, 2011). Values form cultural patterns and customs held by a group or an individual over several generations (Geertz, 2017, p. 42; Livelo et al., 2018; Rudmin, 2009).

Literature suggests three central concepts of social integration: culture shock, acculturation, and culture (or power) distance (Berry & Sam, 2013; Buscemi, 2011). This next section will broadly examine culture shock with a critical discussion of how it can apply to migrants' adaptation to their host country and, more specifically, concerning the experiences of IQNs in Aotearoa. Finally, sections on acculturation and culture (power) distance (Choi et al., 2019) will be outlined to describe how this may affect the IQNs' transition into the Aotearoa nursing workforce.

Cultural Shock

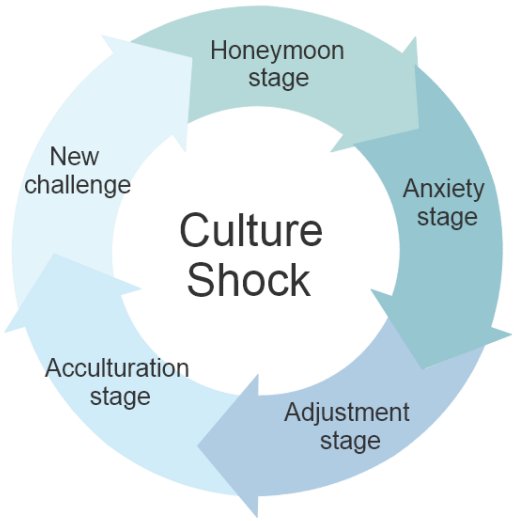
Culture shock has several phases that eschew different characteristics and has its final phase as acculturation (Berry, 2005; Sam, 2015). The phenomenon of culture shock happens in phases initiated by a move from the original environment and social circle to a new and unfamiliar one (McFarland, 2008; Winkelman, 1994). The most well-known model of culture shock was first posited in 1960 by Oberg and comprised four stages: the 'honeymoon stage', the 'anxiety reaction stage', the 'adjustment or recovery stage', and the final 'adaptation or acculturation stage' (Dutton, 2011). According to Winkelman's (1994) interpretation of Oberg's model, the 'honeymoon stage' is where people are excited about the new culture they are inhabiting. This phase can begin when IQNs enrol onto a CAP course, migrate to Aotearoa, and meet in class for the first time. They may tend to

have a positive outlook on the differences in the provision of nursing care and be idealistic about them.

Following a culture shock cycle (see Figure 1), this positive outlook may change to the 'anxiety stage' where the person finds the new culture negative. In this stage of undertaking the CAP course, the IQN may compare their new local professional culture with their previous one and see minor issues as more significant problems. For example, working with new ethical practices that contradict prior home country values, such as palliative care provision, may engender confusion and unhappiness with the new systems, as found in a study of IQNs in Aotearoa (Brunton & Cook, 2018). Loneliness and homesickness may ensue, with bitterness towards the new culture and an inability to take on board the new processes. They may prefer to socialise with people from their home country during the course and feel emotionally fatigued by the constant adaptation to differences. Stage three of the cycle, the 'adjustment stage', is where people make more efforts to adjust to the new culture and find the ability to react positively and optimistically to new and previously misunderstood challenges (Dutton, 2011). However, this stage may not occur during or close after undertaking the CAP course. IQNs may move to another employment area, necessitating the beginning of another culture shock event and extension of the acculturation process (Jenkins & Huntington, 2016).

Figure 1.

Adaptation of Oberg's (Dutton, 2011) and Winkelman's (Winkelman, 1994) culture shock models



The final stage in the culture shock cycle is 'acculturation' when people realise that the new culture is manageable and can confidently adapt to the differences while still keeping their own cultural values and identity. However, movement through the stages is not always linear and can be cyclical. Influences from personal circumstances and experiences will require further adaptations and adjustments. Indeed, many may not reach the final stage of acculturation in the cycle. Nevertheless, movement through the culture shock cycle can support a more beneficial and positive transition into a new workplace when managed with an understanding of the changes experienced by migrants.

IQN Acculturation to Aotearoa Nursing Workforce

The acculturation phase is the most critical response to a new culture and determines individuals' interactions (Berry, 2005; Berry, 2008; Cherry & Lucas, 2017; Shafaei et al., 2016). Hui et al. (2015) outlined two distinct modifications to the person undergoing the transition to a new culture: socio-cultural and psychological shift influencing perspectives. Socio-cultural modification is the acquirement and use of appropriate social and cultural skills to successfully live and thrive in a new environment. They further describe psychological adaptation as the emotional responses of positivity and physical wellbeing to the new culture (Hui et al., 2015). Changes in both socio-cultural and psychological outlooks are regularly adapting and coincide, with one influencing the other (Berry & Sam, 2013). There is, however, a difference in how the changes occur as the adaptations follow different routes. Psychological adaptation occurs along a variable pathway of progression compared with socio-cultural adaptation. The person becomes more aligned with the culture in the first instance and then develops resilience to cope with the changes (Hui et al., 2015).

International nurses who migrate to Aotearoa will encounter changes in their social and professional values and may experience difficulties adapting to new experiences. This adaptation occurs within the culture shock cycle, as shown above, and may begin with an initial shock at meeting new and unfamiliar concepts and cultural requirements required to work as an RN. For IQNs in Aotearoa, specifically, it is related to encountering a new work environment, new processes, and the introduction to te Tiriti O Waitangi and its relation to healthcare provision (NCNZ, 2011a). Enrolment on the CAP course for registration purposes provides a brief introduction to legal and practical expectations for nurses from different cultures joining the workforce (NCNZ, 2008). However, as discussed in Chapter 2, there are many differences in cultural and ethical nursing care provision between the Philippines,

India, and Aotearoa as the host country which will, at first, present as shocking to many of the IQNs.

International nurses moving to different countries must adapt to the new processes and systems to obtain registration and work safely in the host country RN role (Cherry & Lucas, 2017). Berry et al. (2011) proposed a framework outlining how the links between cultural groups moving to a state of acculturation can occur. It defines how the groups interact and adapt to the changes through the individuals' psychological understanding and rearrangement of known values and assumptions. Each individual's behavioural and cognitive changes serve to support the formation of new understandings of the new culture and enhance their social connectedness within the new environment. Understanding this concept is helpful when considering the adaptations required for IQNs to move to a new country and a new workplace.

Studies have shown that new IQNs expect to transition into a new work area through a process of integration, with recognition of their prior experience and culture; but realise they will ultimately be required to assimilate into the new area (Lewis, 2021; Valdez et al., 2021).

Assimilation is the domination of the host country's culture and beliefs over the new workers rather than acculturation into the new culture (Lewis, 2021). Many Western countries, such as the USA, UK, Australia, and Aotearoa, focus more on IQNs transitioning into their professional culture as part of employment into the host nursing workforce. However, depending on their own cultural and religious practices (Valdez et al., 2021), it is contended that there is a cultural superiority of host nations. Therefore, it is important to note that IQNs can modify their integration to meet the host country's norms and values while holding onto some of their own on a platform of cultural relativism, also known as liminality (Abuliezi et al., 2021; Choi et al., 2019; Hui et al., 2015).

IQNs Experience of Culture (or Power) Distance

The nursing workplace significantly impacts IQNs' encounters with new cultural norms within their host country. New experiences, techniques, and the use of different professional terminology will form the origins of any culture shock and anxiety (Hui et al., 2015). Navigation through early encounters in the workplace, both professionally and socially, serve to structure the IQNs' understanding of the need to adapt to the new work role. Working between two cultures and seeing how the two are similar, yet different, is known as culture distance (Choi et al., 2019). The concept of culture distance examines how

the two different cultures react to each other whilst also developing interactions (Berry, 2005). In a professional setting, this can be referred to as the power distance. IQNs will form work relationships based on their attitudes to political, social, and individual values, such as the relationships with seniors or managers in the nursing workforce (Hofstede, 2011).

These attitudes and values of interaction, such as reverence for senior staff members and older patients, and previously held ethical values, are linked to the individuals' cultural norms regarding accepting the new difference in power levels as seen in the new organisation (Hofstede, 2011). For example, an IQN may perceive that the host country nurse, who is older than them, is superior and in charge of the workplace, when they may actually be the junior nurse on duty in respect of their more recent nursing graduation and less experience in the workplace. Another example of power distance would be the deference and respect given to the tutor in the clinical area, even though the IQN may disagree with the task allocation and completion methods. However, in the acculturation process, inflexible power distance beliefs can result in avoidance behaviours, leading to disagreement and social isolation (Choi et al., 2019). For IQNs, this may result in non-participation in workplace discussions about patient care or multi-disciplinary team meetings requiring nurse input. As a result, patient care may suffer, and the IQN may not be working to a safe and competent level by avoiding the power level acceptance.

Summary

IQNs' adaptation to a host country's nursing workforce entails different phases of commonly experienced cultural shock, acculturation, and transition to their host society's workforce. Providing standardised culturally safe nursing care for the host country's population is vital and can significantly impact patient wellbeing and population health outcomes. Therefore, examining how the acculturation phases may impact IQNs migrating to Aotearoa to register as nurses is an important context to frame the research approach and critical discussion. The following chapter reviews international and national literature relating to IQN transition and acculturation into host countries' workforces and the issues encountered therein.

Chapter 5 Literature Review

The previous chapter highlighted the acculturation concepts and theories applicable to IQNs migrating to host countries. It examined the concept of culture shock, the phases of acculturation, and the presence of power distance when working between two cultures.

This chapter will present the reviewed literature underpinning the research topic and outline the databases and search terms used. Outlined will be both the national literature from Aotearoa concerning the transition to practice in nursing for IQNs and the global empirical research. Finally, it will identify the gaps in the literature linked to the research aim and research questions from which the ontology and methodology shape the subsequent chapter.

Literature Review Method

Key databases such as CINAHL, Cochrane Library, Ovid Medline, Scopus, and Google Scholar, were used to search for literature to inform the research topic. Additionally, hand searching of the reference lists of the peer reviewed journal articles revealed linked articles cited by the original authors. Initially, search dates were from 2010 to 2016, as this was the previous five years from the commencement of the research process. However, as the research analysis progressed, subsequent search dates were identified as 2005 to 2021, the year preceding the final stages of the thesis completion. Search terms employed were ‘acculturation’ or ‘transition’ ‘issues’ combined with ‘migrant’, ‘internationally qualified’, and ‘overseas trained’, with ‘nurse’ being the critical word. Initially, 289 articles were identified, and this number decreased to 125 by excluding articles not written in English and duplicated results.

Further examination of the article abstracts led to the exclusion of studies without specific relevance to the topic leaving 43. The subsequent review of these articles, and more online searches via Proquest and Google Scholar, identified articles with specific words such as ’experiences’ and ‘perceptions’ combined with acculturation and transition of nurses, and brought about a selection of grey literature articles for review bringing the number for consideration to 36. In addition, to the research-based articles, a selection of grey literature from web accessed searches and opinion pieces was also considered and presented to give a further contextual overview to support the research topic. Finally, following further review, 20 research articles and three grey literature articles were chosen for presentation and themed integrated discussion (Sandelowski, 2000) to form the underpinning focus for

the research aims and questions of the current study. These themes were: IQN integration into new healthcare systems, cultural conflict, socio-cultural barriers, and professional dissonance.

This chapter will present the empirical evidence identified from the reviewed literature on identified IQNs' issues in integrating into a new healthcare system. It will outline IQNs' integration into new healthcare systems, acculturation into a new workforce environment, cultural conflict and socio-cultural barriers and enablers met in the integration process. Next, it will outline the professional dissonance arising from clinical competency barriers. Finally, it will present the challenges and enablers to transition and acculturation of IQNs into Aotearoa's healthcare system. Additionally, the cultural safety aspect of integration into Aotearoa is identified and presented.

Internationally Qualified Nurses and Integration into New Healthcare Systems

A more definitive description of professional acculturation in nursing is the process of integration into a new healthcare system (Feltrin et al., 2019; Neiterman & Bourgeault, 2015; Nortvedt et al., 2020). It is a complex process of modifying familiar professional work roles and transferring learned clinical skills to the new workplace expectations. It can result in the nurse experiencing the culture shock of having to learn new protocols of care provision, management of different types of treatment, a new hierarchy of authority in the workplace, and learning the local aspects of cultural values (Choi et al., 2019; Liou et al., 2013; Pung & Goh, 2017; Roth et al., 2021). Movement from one clinical area or ward to another can also require this type of adaptation. Challenges in learning new techniques of nursing practice and ward-based routines are experienced by most new staff when commencing a new role in a new clinical area (Skaria et al., 2019). However, a more profound modification and transition must occur when migrating to register and work as nurses in a different country.

Research shows that many IQNs who have migrated to another country for employment can have great difficulty in transitioning to their host country's workforce and society due to issues with communication and socialisation. Additionally, professional issues due to encountering differing nursing practices and workforce hierarchy may impact the acculturation process (Abuliezi et al., 2021; Brunton et al., 2019; Goh & Lopez, 2016; Liou et al., 2013; Newton et al., 2012; Nortvedt et al., 2020). The processes of assimilation and adaptation to the professional nursing values and practices in the IQNs' chosen destination country may take decades, and others find it too challenging to work through and may not

adapt at all (Brunton et al., 2019). Factors such as workforce discrimination and technical differences in nursing practice can lead to IQNs becoming disheartened at work and ultimately choosing to leave their host country and return home (Chok et al., 2018; Nourpanah, 2019). Understanding the issues and challenges faced by IQNs can support more favourable work conditions and a better transition into the new workforce and will result in better staff retention for the host country (Montayre, 2016; Montayre et al., 2018; Pung & Goh, 2017; Ramji et al., 2018; Wellard & Stockhausen, 2010).

Acculturation into a New Workforce Environment

Successful acculturation into the new nursing work environment can lead to increased work satisfaction, a sense of belonging, and personal achievement (Adobo et al., 2020; An et al., 2016; Goh & Lopez, 2016). Furthermore, finding solutions to challenges and accessibility of workplace support programmes can support IQNs to become more settled in the workplace and to feel more welcomed into the workforce community (Cherry & Lucas, 2017; Covell et al., 2017; Högstedt et al., 2021). In addition, the initialisation of successful cross-cultural integration programmes has led to better working relationships between the host country's nursing workforce and the IQNs working beside them (Brunton et al., 2019; Hui et al., 2015). It follows, therefore, that feelings of job satisfaction occur as the result of IQNs feeling welcomed and supported by their host country and employers.

Cultural Conflict

The IQNs reportedly experienced cultural conflict regarding the issues they felt uncomfortable with during the dynamic change in cultural adaptation. Research studies discussing the need for culturally safe nursing practice by understanding the possibility of confusion stemming from different cultural understandings around gestures and body language is available regarding generalised health care provision (Tuohy, 2019; Wilson, 2012). However, the literature is not explicit regarding how this may limit IQNs' acculturation or transition to a host country's nursing profession. As discussed previously, professional nursing interactions rely on the accurate and timely transference of information. Without the proper understanding of non-verbal and verbal communication, difficulties can and will arise.

Equally, considering the possibility of the IQN's cultural nursing norms of avoiding conflict and showing passivity, a misconception of a communication event could occur. Perceived body language at the time of conflict may also reflect this, and misinterpretation of lack of confidence or inability to understand the situation is likely (Wilson, 2012). Observation of a

nurse who is inclined to stand and wait for instructions from the doctor or senior nurse rather than make decisions based on their assessment could infer that they are unsure what action to take. The observer may then form an opinion based on *their* prior cultural expectations of the role rather than giving credence to the IQN's prior nursing cultural norms. Intolerance and any resulting covert racism, if not managed, will lead to ineffective teamwork and care provision if left unchallenged, and may also lead to exclusion from the team and workplace. Accordingly, research reports feelings of isolation due to a lack of competency in the local language are significant regarding IQNs' adaptation to a new job and their migration experience (Viken et al., 2018).

Further demarcation of the conflict between host and destination nursing professional cultures has four main concepts; communication difficulties, discrimination from the host country's workforces, clinical differences such as registered nursing role expectations, and social-cultural displacement (Chok et al., 2018; Nortvedt et al., 2020). In addition, exploring how the host country could support IQNs to transition into the local workforce appears in the literature together with a determination of how this could occur, and led to identifying two main themes: socio-cultural barriers and professional dissonance. Further, constructed discussion arising from socio-cultural barriers occurs under the sub-themes of communication difficulties and social-cultural displacement. Professional dissonance is presented under clinical competency barriers and professional discrimination sub-themes.

Socio-cultural Barriers

Communication barriers. Communication is the primary method of passing on information and is vital in human interactions, especially in nursing. The ability to care for someone appropriately relies on being aware of their needs and having the capacity to provide them. Poor patient outcomes, lack of treatment provision, and undiagnosed health issues may result from a failure to understand the needs of the client presenting for healthcare provision (Brunton et al., 2019). Patients who cannot communicate their needs may not receive the appropriate treatment. Likewise, nurses who cannot communicate with patients may not correctly assess their needs or provide the required interventions for health improvement. In addition, poor communication skills will lead to inadequate professional interactions and significant implications for safe treatment provision (Zanjani et al., 2018). Nurses, therefore, need to be confident in their communication skills and able to interview and assess patients to correctly ensure patient safety. Equally, patients and

colleagues need to be confident in their information about the health condition being reviewed and managed.

In support of this concept, communication is the most critical theme acknowledged in studies regarding effective transition into a host country's nursing workforce (Brunton et al., 2019; Chok et al., 2018; Korzeniewska & Erdal, 2019; Zanjani et al., 2018). Several studies were undertaken in Sweden, Australia, and Oman with IQNs describing adverse outcomes resulting from low fluency levels in English (Högstedt et al., 2021; Philip et al., 2019; Valdez et al., 2021). Having English as a second language resulted in many instances of poor communication by the IQNs. For example, participants in the Swedish study reported they had deliberately ignored patients through their own discomfort in talking with them, thereby not assessing their needs appropriately. Notably, in cross-country and Australian qualitative studies, IQNs' misconceptions in translating local colloquialisms highlighted a need to learn the local professional terminology to promote patient safety (Brunton et al., 2019; Chok et al., 2018; Goh & Lopez, 2016; Philip et al., 2019).

Furthermore, communication was acknowledged to be one of the most challenging parts of the acculturation process for IQNs. One specifically identified factor in language use, critiqued by Brunton et al. (2019), is that cultural safety issues can result from cultural (mis)communication. For example, phrases used by nurses from a different culture to that of the IQN's society may manifest as insults rather than compliments. To illustrate, the authors offered an example regarding findings and interpretation of body assessments, such as weight, that can be misunderstood if the IQN has a different cultural value placed on how good health is identified and defined in their home country and culture. In addition, IQNs' use of their first language in the workplace was reported to have been deemed inappropriate, rude, and discouraged, especially when in front of patients (Brunton et al., 2019; Chok et al., 2018; Valdez et al., 2021).

Lacking Confidence. Studies into IQN transition into the workplace identified close links between low confidence levels and poor communication with both staff and patients, reinforcing the language issues faced in the new work environments (Brunton et al., 2019; Liou et al., 2013; Montayre et al., 2018; Valdez et al., 2021). Experiences of hearing and learning to differentiate several different accents and the lack of understanding of the nurses' communication by the patients will further compound the negative experience for IQNs and lead to inadequate nursing care provision quality. Insecurity related to the IQNs' lack of English fluency also impacts their interaction with patients (Philips et al. 2019). Lack

of time to procure interpreters and mistranslation arising from non-medical interpretation can be a significant factor in providing inadequate nursing care (Brunton et al., 2019; Valdez et al., 2021; Zanjani et al., 2018).

In their study in Norway, Korzeniewska and Erdal (2019) considered how interviewed IQNs had refrained from interacting with patients and staff due to their lack of confidence in acquisition of their host country's language. They further examined how this had led to increased patient complaints and professional isolation. Participants in a study by Valdez et al. (2021) were anxious due to lack of ability to speak the host country language and reported relying on sign language and gestures. Equally, feelings of being 'an outsider' and instances of bullying and discrimination were the main themes identified in their study of 30 IQNs from the Philippines and Poland (Korzeniewska & Erdal, 2019). Interestingly, as the 2-part study occurred with a year between interviews, a supplementary finding was how the process of acculturation was time-based. An illustration of this is the provision of details of how the subsequent interviews indicated fewer discrimination issues. However, the study itself was conducted in Norwegian. Therefore, the translation of narratives from interviews undertaken in Norsk may have led to some misconstruction of nuances in the original data resulting in limitations in the presented concepts as might all translated qualitative work.

There can be confusion and different meanings attributed to language and words, leading to mistrust and prejudice. From these studies, it is apparent that IQNs are judged based on their skills, knowledge, and ability to communicate in English. When integrating into the host country, IQNs must negotiate their new professional roles while simultaneously being familiar with the socio-cultural norms in their everyday lives. Additionally, learning new terminology for interpersonal and interprofessional communication will substantially impact the IQNs as they negotiate the integration into the new culture both socially and professionally. Finally, what emerges from the studies discussed is that confidence in communication in the host country's nursing workforce appears to grow over time for IQNs, together with an increased feeling of inclusion in the workplace.

Nevertheless, the contention is that, given time, IQNs are more adaptable than the host country's workforce. For example, studies outlining cross-cultural awareness training and learnings about different cultural languages supported IQNs to form more cohesive teams with their colleagues (Gillham et al., 2018; Ramji et al., 2018). Use of a buddy or mentorship system with the IQN, partnered with someone in the workplace, was shown to support

learning tolerance and respect for each other's culture. Moreover, it significantly impacted both the nurse and the mentor equally (Gillham et al., 2018). As many IQNs may be unaware of the language and cultural differences, implementing an extended supportive environment focusing on sharing knowledge and language may be the key to a less damaging and stressful transition into the new workforce. The study shows that a host nursing workforce that provides education and support would facilitate better communication and cohesive teamwork.

Enablers to Transition

Several successful approaches to transition into a host country's workforce outline mentorship programmes, education modules, and extended orientation plans used to address the issues identified by both the host country and IQNs. Mentorship programmes that include cross-cultural information sharing have been demonstrated to provide a welcoming and supportive environment (Gillham et al., 2018; Ramji et al., 2018). These studies have provided insights into how staff involvement in developing educational transition frameworks and modules may provide information about the differences in culture, give co-ownership of the outcomes, and positively affect better working teams for healthcare provision.

Comprehensive education through specific modules or extended orientation plans and cultural awareness seminars and workshops is documented to provide the best level of support for IQNs and offer a more valuable method of acculturation into the new team. In addition, studies have shown that addressing the difficulties and issues expressed by the host country's nurses effectively brings about cohesive teams and supportive workplaces (O'Callaghan et al., 2018; Ramji & Etowa, 2018; Ramji et al., 2018). In contrast, workshops on evidence-based practice and its use are seldom encountered in non-Western countries (Korzeniewska & Erdal, 2019). Therefore, introducing cross-cultural learning through modular education sessions and intercultural student groupings may have supported IQNs to develop their work patterns and approaches more confidently (Gillham et al., 2018; Korzeniewska & Erdal, 2019; O'Callaghan et al., 2018).

Notably, most international studies on the acculturation of migrant nurses highlight barriers posed on verbal communication issues as the main themes identified. The misunderstanding of terminology and miscommunication, leading to low professional expectations from the host country's healthcare environment, are essential topics underpinning the noted challenges in communication. However, whilst the aforementioned

is of great importance, consideration for non-verbal communication issues should also be given, especially in the nursing profession, where it may not always be appropriate or realistic to rely on verbal encounters. Furthermore, whilst interpersonal and interprofessional communication skills for providing safe and competent patient care are essential for nursing care provision, so is the need for compassion and reassurance by non-verbal means to enhance workplace professionalism and support.

Socio-cultural Displacement

Socio-cultural displacement occurs when interactions with a different social group occur in an unfamiliar environment or with unfamiliar people. For example, IQNs entering a host country must encounter new and unfamiliar interactions with their nursing colleagues in the host country workforce. In addition, host country workforces may not always support IQNs entering their profession, and this lack of support can negatively impact subsequent interactions and acculturation processes.

Studies investigating IQNs' self-perceptions of being disliked, challenged, and confused by their host country nursing colleagues in their interactions show how the formation of poor interpersonal relationships in both professional and social environments lead to a lack of self-worth and exclusion from society (Chok et al., 2018; Valdez et al., 2021; Viken et al., 2018). Frustration during professional encounters such as the transmission of information about patient care was described as occasionally bordering on intolerance and, in some instances, likened to racially based comments (Philip et al., 2019). Adverse experiences that affect IQNs can compromise patient safety and socially impact the nurse, who may be reluctant to socialise with colleagues. This social and professional isolation may ultimately lead to adverse impacts on the IQNs' mental health and wellbeing, decreasing morale and leading to high staff turnover (Högstedt et al., 2021).

Other factors associated with poor team cohesion in the professional workplace between IQNs and host country nurses can occur with differences of opinion based on cultural ethics. Palliative care provision is one of the areas where negative associations towards cross-cultural ethics have been noted as an issue when confronting challenges around the death and dying processes were described (Brunton & Cook, 2018). An example from the study included the Filipino nurses' reluctance to talk about spiritual matters with the patients or their families in a hospice setting. In addition, challenges to IQNs' cultural and religious values on providing curative treatment for all patients at all times, when faced

with providing comfort or palliative care instead, depict the ethical dilemmas (Brunton & Cook, 2018; Philip et al., 2019; Zanjani et al., 2018). Furthermore, IQNs, although described as pragmatic and able to modify their nursing care provision, were reported as having struggled to adjust their approach to working in the new culture. Finally, these studies highlight how discomfort with cultural disparities may increase feelings of isolation and anxiety for IQNs, leading to feelings of not belonging to the team and being treated as 'strangers'.

Perceptions of discrimination and unfair treatment in the workplace can lead to IQNs seeking support from their cultural peers and excluding interactions with their local communities. For example, studies on IQN experiences of embarrassment, frustration, and humiliation caused by low self-esteem and self-worth, illustrate how adding these stresses into the new work role adjustment can negatively impact IQNs' integration (Chok et al., 2018; Zanjani et al., 2018). In addition, feelings of loneliness and alienation may result in disengagement from the workplace and an unwillingness to socialise with nurses in the host country (Connor, 2016; Nourpanah, 2019). Similarly, in their study of IQNs' acculturation into the Australian nursing workforce, O'Callaghan et al. (2018) concluded that some participants experienced negative impacts on their wellbeing. These impacts were felt to be due to their chosen support groups' ideologies supporting their preconceived perceptions of marginalisation. However, other research into IQN transition into a new workforce showed that having a connection with familiar cultural groupings within their local communities led to helpful support systems for the newcomers to the area (Brunton et al., 2020; Connor, 2016). These studies show that differences in the nursing culture of Western and Asian nurses can create issues and stresses, resulting in disagreement, leading to dissension and conflicts. As discussed in the previous chapter, nurses from the Philippines and India come from a more passive social culture. Therefore, when faced with stress and conflict, they may be unable to compromise their deeply embedded values.

Professional Dissonance

Professional dissonance can be described as discomfort or anxiety experienced by a person who encounters conflicting differences in their preconceived professional role values.

Clinical Competency Barriers

Many IQNs have been shown not to adapt well to the host country's professional clinical practices despite undertaking professional educational transition programmes. Instead,

they chose to carry out their nursing role as ascribed in their home country, such as task-focused practice (Högstedt et al., 2021). Examples of IQNs feeling deskilled and devalued relate to the restrictions applied in clinical skills usage for host country role expectations and are reported as barriers to integration into the new nursing workforce (Stievano et al., 2017; Viken et al., 2018). In addition, IQNs reportedly misunderstood concepts of patient-centred approaches to care provision in the host country, and consequently showed more difficulty meeting local ethical and competency-based assessments (Nordstrom et al., 2018; Viken et al., 2018). These recent studies show that despite having received training in technical skills and clinical practices in their own country, the identified lack of understanding fuelled the host country nursing professions' perception of IQNs being poorly skilled in humanistic and patient-centred care.

In addition, host countries are shown to recruit IQNs to be employed directly into the aged care sector workforce (Gillham et al., 2018; Högstedt et al., 2021), a clinical area they are unfamiliar with due to the lack of such establishments in their home country. For example, as stated in Chapter 3, the Philippines and India have few formal institutions for caring for the elderly. Historically, families tend to provide this care in their own homes (Gill, 2018; Nortvedt et al., 2020). Many IQNs, therefore, are unfamiliar with their host country's healthcare system's expectations of caring for older adults with dementia, for example (O'Callaghan et al., 2018; Zanjani et al., 2018). Similarly, despite acknowledging the requirement for undertaking complex assessments for older patients, IQNs reported a loss in their acute clinical skills in aged care (Zanjani et al., 2018). As outlined in Chapter 3, prior nursing education in their home country has many clinical tasks such as IV medication administration or complex cardiac procedures. Often, unfamiliarity with equipment is the main variation in practice experienced (Valdez et al., 2021). Many IQNs report feelings of being under pressure to become more assertive and skilled at decision-making, resulting in a lack of workforce retention (Skaria et al., 2019). Finally, lower professional status and lower pay may combine with the stresses outlined above, leading to a lack of professional confidence and uncertainty in making judgements and decisions in the clinical environment.

Although communication and education are valid suggestions for future safe patient care and cohesive teamwork (O'Callaghan et al., 2018; Philip et al., 2019), most international research highlighted the challenges and issues for IQNs entering a host country workforce. The descriptions from the literature provide a clear illustration of how IQNs are moving within the culture shock phase in action (Brunton et al., 2019; Valdez et al., 2021). Moreover, they give valuable credence to the difficulties encountered with communication

challenges and lack of professional confidence in the act of integration and acculturation to the host county's nursing workforce. Notably, there has been a dearth of literature around providing systems and processes to enhance the work/life balance for IQNs. Aotearoa needs to recruit from international nursing cohorts to enable adequate workforce numbers. Therefore, it is essential to review the national literature regarding identifying issues and challenges for IQNs and the remedial solutions presented.

The following section will review national literature to date on the expectations, barriers, and enablers to transitioning to Aotearoa's international nursing workforce. It will outline the ongoing recruitment and retention of migrant nurses into the local nursing profession and the transition and acculturation processes previously identified for the IQNs.

Aotearoa Transition and Acculturation of IQNs into the Nursing Workforce

Aotearoa has recruited IQNs into its nursing workforce since the 1990a, as outlined in Chapter 2. Similarly, this recruitment has challenged the ensuing transition and acculturation for IQNs into the nursing workforce. The current literature review undertaken for this research provided information about reported historical antecedents and is presented with relevant professional conversations and opinion pieces from grey literature. Discussion on the arising themes of challenges to IQN acculturation and the concept of cultural safety regarding Aotearoa nursing care provisions are outlined.

Prior to 2020, many IQNs have found it challenging to obtain employment with some DHBs and private employers due to work visa restrictions. Discussions between myself and facility managers in aged care and hiring managers in DHBs suggest this was due to the cost of supporting the IQN to obtain a visa without the assurance of a statutory return of service employment period. In addition, lack of commitment to remain with the sponsoring employer led to the IQNs resigning within a short time frame, as they found another job. These discussions further suggested that this had left employers out of pocket and short-staffed, leading to further recruitment costs, particularly in aged care.

As outlined in Chapters 1 and 2, 27% of RNs employed in Aotearoa are known to be IQNs, and around 40% of these nurses work in aged care (NCNZ, 2020). However, with a predicted rise to 50% of all IQNs having employment in aged care facilities in 2025, there is a need to support IQNs to gain registration and be retained in this clinical area (NCNZ, 2013).

Meeting the challenges and adapting to integration into the Aotearoa nursing workforce is a dynamic process that occurs over time, as described in Chapter 4, and will require support (Adams & Kennedy, 2006). For example, many IQNs in Aotearoa failed to gain nursing registration and continue to work as healthcare assistants due to the inability to meet the challenges of adaptation to unfamiliar clinical practices, communication difficulties, and cultural differences (Woodbridge & Bland, 2010). Similar challenges documented for Aotearoa IQN RNs show that this was due to the fact that they have been found not to have engaged in critical thinking for decision making in health assessment in their own country. In support of this finding, IQNs have stated that they subsequently have had minimal experience or support through their attendance on a short CAP course (Bland et al., 2011).

Challenges

Key findings from the literature are communication barriers (Skaria et al., 2019; Wright, 2009), clinical practice differences (Bland et al., 2011; Riden et al., 2013), racism encountered in the workplace (Brunton et al., 2020), and research findings suggesting a need for increased support for IQNs' orientation periods (Hogan, 2013; Walker & Clendon, 2012; Walter, 2017). Finally, findings on challenges in cultural safety implementation into IQNs nursing service provision (Brunton et al., 2020; Montayre et al., 2018) are presented and critiqued.

Although Aotearoa encourages the migration and registration of IQNs into the nursing workforce, there is a limited amount of research on the experiences of IQNs and associated acculturation rates whilst transitioning into the workforce (Bland & Woolbridge, 2011; Jenkins & Huntington, 2016; Walker et al., 2012). However, several articles published in grey literature illustrate anecdotal instances of issues with IQN communication, infection control practices, working with autonomous practice impacting decision-making, and relationships with authority figures (Wright, 2009). Other opinion-based pieces discuss racism towards international nurses, mainly Filipino nurses, and how immigration agencies exploited them financially (Manchester, 2005). Similarly, further articles present discussions about how IQNs' aged care employers also took advantage of the Philippine nurses unfamiliar with Aotearoa employment law to demand rostering on hard to fill shifts such as weekend and night shifts (O'Connor, 2005). Highlighting these issues in the media helped to focus on the needs of the IQNs and the support they would require to transition into the Aotearoa nursing workplaces. Further studies and investigation into IQNs in Aotearoa are discussed below.

Institutional Racism. In 2008, a national study using quantitative and qualitative methods by the NZNO examined the place of work and orientation experiences of IQNs in Aotearoa who arrived after 2007 (Walker et al., 2012). Findings showed the cohorts' intention to remain in Aotearoa, the discrimination they had faced, and whether they had met their expectations of nursing in their chosen host country. The results were comparable to international research (Goh & Lopez, 2016; Newton et al., 2012; O'Connor, 2016), specifically regarding the IQNs' experiences of language barriers, racial discrimination, and the host workforces' disrespect for their previous training. However, a notable limitation of this study was the use of email addresses for contacting participants. This factor may have precluded nurses who were not NZNO members and those whose email address was no longer valid. In addition, the results obtained from the online survey relied mainly on the scoring of statements presented, although offering free-text boxes for further explanation as a choice.

Nevertheless, Walker et al.'s (2012) conclusion prompted the development of a 'good practice' guide, which is now available online from the NZNO, to assist employers to support IQNs and help retain them in the Aotearoa workforce (Walker & Clendon, 2012). A key recommendation of the researchers was for further investigation into the acculturation process of IQNs in Aotearoa, mainly from locally educated nurses' perspectives. In addition, the need to undertake further research was identified due to the complex nature of the issues involved and reported on.

Woodbridge and Bland (2010) undertook a critical review of the literature on IQNs' acculturation and socialisation into the Aotearoa nursing workforce. As a result, they too recommended further researching the acculturation of IQNs migrating to Aotearoa, stating a need due to the increasing numbers of IQNs in the nursing workforce. Subsequently, in 2011, they reviewed qualitatively the experiences of Indian nurses who had completed a nursing qualification in India provided by an Aotearoa education provider and then had moved to Aotearoa to gain employment. The findings mirrored those in the studies undertaken by Walker and Clendon in 2008 and those carried out internationally (Goh & Lopez, 2016; Liou et al., 2013; Newton et al., 2012). For example, all the studies cited communication difficulties, professional language issues, and institutional racism as issues for IQNs. However, the main limitations for Woodbridge and Bland were that the participants were already aware of Aotearoa's nursing practice methods and nursing knowledge curricula due to their education on Aotearoa assimilation before migrating and the small participant sample size. Therefore, although the data are congruent with other

international studies on migrant nursing workforces, it may not reflect the Aotearoa Indian IQN population as a whole.

In 2016, Jenkins and Huntington explored the transition of IQNs in a large residential care facility recruiting six IQNs, five from the Philippines and one from India. Focus group participation provided themes of three phases of transition for the nurses. Findings were similar to the literature previously discussed. In addition, physical, social, and professional experiences such as moving to a new country, learning a different social culture and language, and technical communication were presented as significant factors in managing the transition. The results, however, could have been more generalisable if a greater number of participants had been recruited and from more than one facility. Consequently, the findings may not be transferable to the total IQN population in Aotearoa.

Enablers to transition

There are, however, several suggestions for enabling a smoother transition to the nursing workforce in Aotearoa, arising from studies undertaken into the needs of newly registered IQNs.

Supported Workplace Transition. Further research into workplace transitions for IQNs was undertaken by master's students in Aotearoa, resulting in proposed institutional programmes and guidelines for the transition. For example, in their master's theses, Walter (2017) and Hogan (2013) both identified that longer supervised orientation periods for newly registered international nurses were vital for better acculturation into the workplace. In addition, the theses highlighted possible amelioration of identified issues in patient safety, such as communication issues and working in unfamiliar clinical areas. Similarly, a case study undertaken in Dunedin, Aotearoa, by Otago Polytechnic and Mercy Hospital, considered a collaborative approach to the transition of IQN staff into the new workplace (Davis & Harvey, 2018). The resulting strategies employed by the hospital are currently being rolled out to other Mercy group institutions in Aotearoa to support the integration of IQNS into their local workforce.

Clearly, enhancing the precepting of international nurses depends on the organisation recognising the need for such a process and having the capacity to implement support and training for IQNs. From the commencement of the registration process to the ongoing registration as a RN in Aotearoa, there is a need for education and reflective practice. Critical thinking is vital for supporting and developing the practice of IQNs from countries where this is not present in their nursing education curriculum (Vernon et al., 2011).

Therefore, education on critical thinking underpinned with cultural awareness and cultural safety in nursing is paramount to contributing to safe, effective, and efficient nursing care provision (Adams & Kennedy, 2006; Roth et al., 2021).

Cultural Safety

As outlined in Chapter 2, IQNs entering the Aotearoa nursing workforce encounter a different cultural system in society and the healthcare system. Therefore, cultural safety in nursing is a major component for RNs in the nursing workforce and is one of the primary standards required for IQN registration. Dianne Wepa's (2005) concept of cultural safety and Mason Durie's Te Whare Tapa Wha are core components of education for IQNs wishing to gain Aotearoa nursing registration (NCNZ, 2015a). Accordingly, any IQNs wishing to register and work in Aotearoa as RNs have the challenge of learning to assimilate both cultural perspectives into their practice alongside the challenge of learning and understanding how to work in a new health system (Wright, 2009).

The literature suggests that IQNs will remain in their host countries if supported (Riden et al., 2013; Walker et al., 2012), so it would follow that education and support in language acquisition, and cultural safety knowledge, would be conducive to achieving this. The International Centre on Nurse Migration's report for the WHO (2020) also contends that the achievements and positive practice initiatives of the host country's employers of IQNs are significant in retaining staff (Buchan et al., 2018).

Aotearoa has an intrinsic dual cultural system and actively promotes the values and beliefs of both parties, Māori and Tauiwi[2] (non-Māori), in its national heritage (Wright, 2009). This concept is known as biculturalism (Durie, 1988; Wepa, 2005). Aotearoa uses the term cultural safety in conjunction with biculturalism rather than transcultural nursing.

In addition, many IQNs have migrated to Aotearoa from countries where their family, not nurses, carry out the patient's basic care (see Chapter 3). Therefore, as discussed previously, palliative care and gerontology nursing concepts are new to them as elderly relatives are usually cared for at home by their families (O'Connor, 2016). Notably, ethical issues faced by IQNs in Aotearoa nursing, such as palliative care for terminally ill patients rather than active life-saving procedures, are anathema to some IQNs. As a result, many IQNs are unsure how to respond to the patient's family or carry out the activities of daily

[2] 'Tauiwi' is a term used in recent times to describe people who are not Māori. In this context, it is used as opposed to Pākehā which has also recently been used in the Māori language as a term for non-Māori New Zealanders who are "of European descent".

living care (Montayre, 2016). Written and spoken language, accent, pronunciation, and differing terminology can also lead to misunderstandings in clinical practice. The resulting concerns around communication create tension and stress for staff and patients (Bland & Woolbridge, 2011; Jenkins & Huntington, 2016; Wright, 2009), further supported by Brunton and Cook (2018; Brunton et al., 2019; Brunton et al., 2020; Choi et al., 2019; Cook & Brunton, 2018; Stoddart, 2018). This is indicative of increasing attention to how different cultural values of IQNs versus Aotearoa educated nurses affect communication and collaboration needed for effective teamwork. The conclusions highlight the need for understanding between both the IQNs' attributes and those of Aotearoa society and the nursing profession to overcome the cultural dissonance that emerges (Cook & Brunton, 2018).

Summary

International nurse migration has become a well-established phenomenon in response to a global shortage of nurses, and international nurses' professional, financial, family, and personal aspirations. Developed countries have continued to employ IQNs due to economic health reforms impacting nurse training and budget cuts in health service provision since the 1990s. an ageing workforce, and rapid and recent population and health changes - aged care- co morbidities, Aotearoa will need to continue to recruit IQNs to fill these gaps. However, the rising numbers of IQNs registering to work in Aotearoa brings many complexities concerning their acculturation into the nursing workforce. This literature review considered the themes of integration into a new healthcare environment, socio-cultural barriers and enablers, and professional dissonance for IQNs globally and in Aotearoa. The sub-themes of communication barriers, lack of confidence, and socio-cultural displacement were first outlined and critiqued. Next, professional dissonance was presented with a clinical competency barrier sub-theme. Finally, the Aotearoa literature was presented and critiqued, illustrating the challenges for IQNs acculturating into the nursing workforce, such as communication issues, institutional racism, and cultural safety.

Due to the decrease in the nursing workforce globally, and the demands on nursing from challenging times such as the COVID-19 pandemic, research into professional acculturation in nursing is becoming more critical. However, there is minimal research into the acculturation of IQNs into Aotearoa, and most literature concentrates on the barriers faced by IQNs in the workforce on joining the nursing workforce. Furthermore, there is no peer-reviewed work to date on IQNs' challenges and barriers to working in Aotearoa. Instead,

this information appears in grey literature that provides anecdotal reports of the challenges identified by Aotearoa educated RNs regarding IQNs joining the nursing workforce. Finally, no studies have identified how, if at all, and in what ways the CAP course components have or have not supported IQNs transitioning into the Aotearoa nursing workforce.

This research addresses the gap in the literature regarding the perceptions of the greatest IQN workforce, nurses from the Philippines and India, on the most significant CAP components from the course and whether they felt it supported their subsequent transition into working in Aotearoa as an RN. In particular, a focus on the significance of the clinical practice component on the CAP regarding knowledge and experience of the RN role in Aotearoa will be explored, as well as the gap in the knowledge gained from the cultural safety and te Tiriti O Waitangi CAP content and its perceived significance for and subsequent understanding by the participant IQNs in their current RN roles.

Chapter 6 Research Design, Methodology, and Methods

This chapter outlines the ontology, epistemology, research design, methodology, and methods used in researching participant IQNs' perceptions regarding what differences (if any) in nursing practice were encountered during the CAP and between previous nursing clinical experiences. For example, what clinical accountability and responsibility elements of the CAP were seen as applicable to their practice? How was the concept of cultural safety in nursing similar or different from previous experiences? How did this relate to understanding te Tiriti O Waitangi and its implementation in health in Aotearoa? What other components were seen as satisfactory or unsatisfactory from the CAP experience? Finally, what implications can be drawn, and how can this be used to inform any future IQN nursing registration process in Aotearoa? First, the ontology and epistemology informing the research methodology will be outlined, then the underpinning methodology of focused ethnography and its relation to the research question. Next, I will outline the subsequent methods used to collect the data, including the sampling criteria and rationale for the participants, ethical considerations, and demographic data. Finally, I outline the development and modifications of the interview guide, pilot interview results, data analysis, and rigour of the study.

Ontology and Epistemology

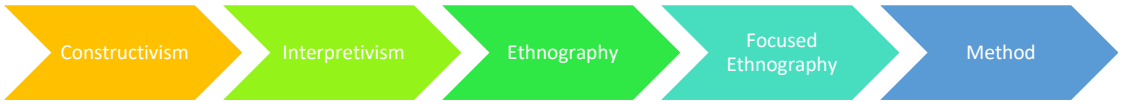
Ontology is a term used in philosophy to define the construct of what exists for a person in their reality, which can further be described as their nature of being or existence (Lincoln & Guba, 1985). Its use in qualitative research has been described as the "study of being" (Crotty, 1998, p. 10) or the search for how we view the world in which we exist (Al-Saadi, 2014). For example, in the current study a key ontological perspective is that of the participants' perceptions of realities in their existence as IQNs working in the Aotearoa nursing workforce. In addition, as the researcher in the study, my ontological perspective acknowledges that I have my own view of reality and beliefs and will work from within this position when seeking and interpreting the lived experiences and realities of my research participants, the IQNs (Potter & Richardson, 2019).

The method of gaining knowledge obtained from the research participants is described as epistemology or the way in which the researcher investigates the world (Al-Saadi, 2014). When considering how to undertake this research, I based the choice of my research framework on a constructivist epistemology, using a theoretical perspective of

interpretivism (Crotty, 1998). Under the constructivist paradigm, there is a belief that no singular concrete events provide the same experience for everyone. Therefore, there can be no objective measurement of individuals' things as they 'should be' (Al-Saggaf & Williamson, 2006). For example, each person has different experiences and understanding of their life and, therefore, will interpret reality in their own way. Each person's reality has been constructed by interactions with their family, the physical environment, and cultural base (De Chesnay, 2015). Interpretivism in this research occurs through my analysis and interpretation of the meanings of the personal interactions and experiences offered by the participant IQNs (Aamodt, 1982) to elicit a wider understanding of the realities of their acculturation into the Aotearoa nursing workforce. To achieve this, I used the methodology of ethnography, specifically focused ethnography, as illustrated in Figure 2.

Figure 2.

Research study framework



In this research study, my position as the researcher has its roots in an anthropological investigation of how two cultural groups have perceived the influences of a particular event on their current life position and acted on it. For example, investigating the research participants' reported behaviours following the CAP course and how this has influenced their nursing cultural understandings provided an analysis of their reactions to the new work and social environment (Streubert, 2011). My worldview drawn from my professional and personal experience is that people's experiences are derived from their interaction with their environments, and their interpretation and use of the information available to them. This information comes from the geography and the social group of which they are a part. I further believe that people continue to learn and react to received input of data from their environment and social interactions and that they learn to manage their responses and beliefs accordingly. Therefore, I decided that the constructivist/interpretive paradigm

aligned with my worldview and that the research question of investigating the IQNs perceptions of the significance of the CAP course on their subsequent RN roles in Aotearoa also fit with this paradigm.

Design

In order to obtain information from participants about their reality and experiences, I chose a qualitative approach for the research (Parahoo, 2014) using what is described as 'naturalistic inquiry'. This approach provides an understanding of a given social world in which the researcher observes, describes, and interprets the experiences and actions of specific people and groups in both a cultural and societal context. The use of a naturalistic enquiry (Lincoln & Guba, 1985) allowed the participants in this study to provide the data as they have interpreted it, in their own words (Higginbottom et al., 2013). Interpretation of the data obtained about the participants' perceived realities to discover or ascertain the implications of significant events for them alone (Higginbottom et al., 2013) occurs by using a methodology that supported finding out by asking the participants about their perceptions.

The research question derived from the literature reviewed— 'what elements of the CAP were significant to IQNs working as RNs in Aotearoa?'—suggested a need for a specific methodology, enabling a distinct emphasis on how the IQNs' cultural backgrounds and previous nursing experience gave them meaning and understanding of general nursing practice in a different country. This methodology, in turn, supported examination of their responses and analysis of their thoughts on how the learnings from the CAP course assisted them in their transition to practice as RNs in Aotearoa. Ascertaining the subjective meanings from the participants' point of view allowed a deep rich 'emic' data into their cultural and professional attitudes and belief values for analysis (Knoblauch, 2005). Emic data are deemed to be a partial glimpse into views of the group's insiders, in this instance, the research study participants (Strandås et al., 2019). As the experience from the participant's point of view was required, a grounded theory approach would not have been suitable as a methodology as there was no preconceived understanding, process, or theory to prove (De Chesnay, 2015).

However, there was awareness of my transition from being a UK trained nurse now working as a RN in Aotearoa. Reflecting on my own experience of this phenomenon, I knew that I would need to position myself in the research and acknowledge that this may influence how I orientated myself to it. Equally, it would affect how I approached the interview

questions and interpreted the results (Van Maanen, 2006). Finally, there was an understanding that additional data from observations of the participants before and during the interview would contribute in the way of an outsider's (or etic) view of the obtained data (Strandås et al., 2019). These considerations are included in the discussion of the findings in Chapter 8.

Methodology

Ethnography

As a research methodology, ethnography has developed from original studies in anthropology that focused on the study of humans and what attributes, attitudes, and values make their social identities (De Chesnay, 2015; Roper & Shapira, 2000). In ethnography, the researcher is looking more at the cultural aspects of groups in their settings from the groups' point of view (O'Reilly, 2009). Roper and Shapira (2000) defined ethnography as "the research process of learning about people by learning from them" (p. 1). They describe the methodology as a collection of formal data and informal recording of the participants' feelings to describe and analyse to provide different perspectives and interpretations of specific topics within cultural behaviours (see Figure 3) (Kane et al., 2006; Roper & Shapira, 2000). Ethnography draws on an interpretive paradigm because it concentrates on examining and exploring narrative descriptive accounts obtained from the interviews of participants and the analysis of the acquired stories (Clarke & Braun, 2017; Polit & Beck, 2017). Key characteristics of all ethnographies are the study of a specific phenomenon to produce unstructured data and some form of observation to interpret the significance and purpose of human behaviour (see Figure 4) (Higginbottom et al., 2013; Kane et al., 2006).

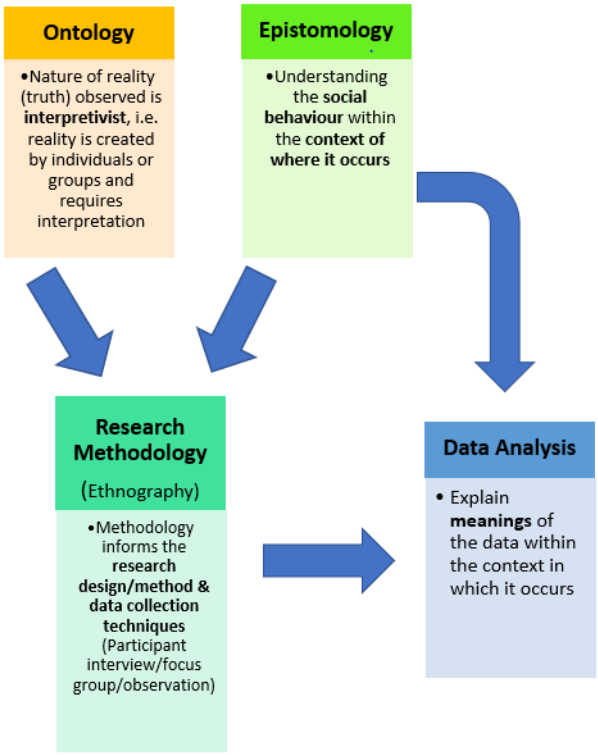
However, there are limitations to ethnographic research as some cultures have evolved over time, leading to some definitions being misunderstood or vital aspects lost as the focus is on narrower perspectives than previous research (Marghalara et al., 2015). The aim, then, of the ethnographic researcher is to learn from (rather than study) members of a cultural group (Knoblauch, 2005).

The definition of a cultural group is a population of individuals connected by sharing the same beliefs and knowledge (Streubert, 2011). In this study, the cultural group refers to RNs trained in Aotearoa, using the nursing professional culture from their education and subsequent work experience. The specific cultural group consists of nurses trained overseas from Aotearoa but have transitioned via a CAP course to RNs. This research aims to identify

what, if any, elements of the current CAP course were significant to their transition to working as RNs in Aotearoa through the use of a focused ethnography.

Figure 3.

Ethnographic research method (adapted from Kane et al., 2006, p. 143)



The intention of the ethnographic researcher concerning the members of a particular cultural group is to interpret their world view and define it. Using the 'emic' or insider perspective (Hoey, 2014; Strandås et al., 2019), the researcher allows the emergence of meanings and categories from the encounter rather than imposing them from their prior assumptions. Eventually, the choice of the qualitative research approach of focused ethnography (Cruz & Higginbottom, 2013) as the methodology for the research was arrived at. This methodology was chosen as the study's main aim was to elicit insight into the perceptions of IQNs on their transition into the Aotearoa nursing workforce after undertaking the RN CAP course. Identification of the experiences and perceptions of the participants using the cultural values of two ethnically different IQN groups, in this instance, nurses from the Philippines and India, was required. Therefore, the research question became about whether they perceived they had gained enough understanding from the

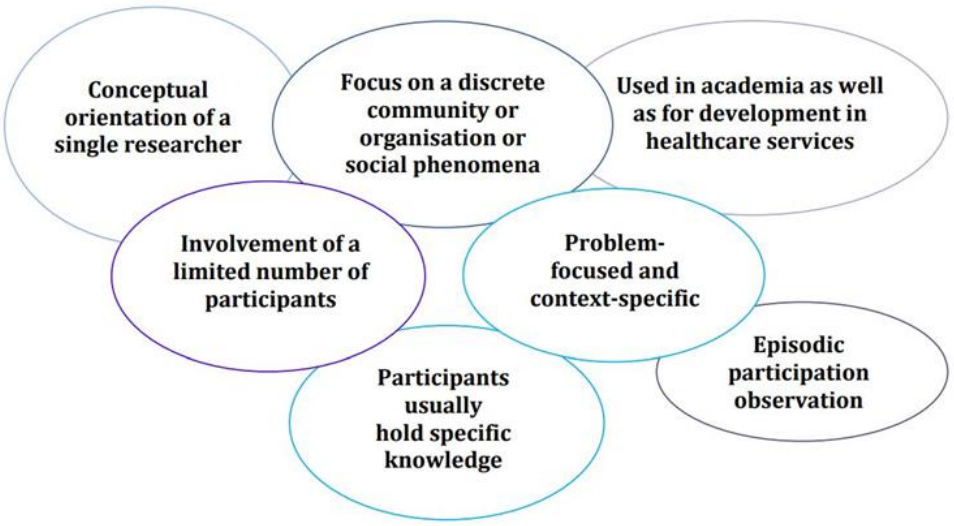
CAP course to provide them with a fundamental underpinning of the notion of cultural safety and clinical competency requirements to work in the Aotearoa healthcare system.

Focused Ethnography

Focused ethnography (De Chesnay, 2015) examines a 'sub'-culture's workings and world views within a given culture. Focused ethnography can further be defined as a method of eliciting narratives from participants in their own words and understandings in order to obtain information about their cultural behaviour in specific contexts (O'Reilly, 2009). Focused ethnography is used to gain and evaluate information on a shared experience or specific topic (De Chesnay, 2015; Higginbottom, 2011) (see Figure 4 below).

Figure 4.

Focused Ethnography model (Higginbottom et al., 2013, p. 3)



In this research, the identified subculture is IQNs in Aotearoa who have specifically undertaken their nursing training in the Philippines and India. The overall culture sits in the professional nursing practice in Aotearoa. Focused ethnography adapted by Higginbottom et al. (2013) defines the underpinning points employed in this study, and the steps are outlined below.

Focus on a Discrete Community or Organisation or Social Phenomena. The underlying assumption is that every group develops a culture of its own that guides its members' world views and how they interact and structure their understanding and profoundly diverse experiences separated by geography, environment, historical interventions, and technology. In addition, the impact of past ancestors and traditions continues to influence culture and how people interpret their world. However, culture has no distinct and objective boundary, and each individual will understand and experience their lived experience differently, despite coming from a similar aspect of the cultural parallels. These views and phenomena are compatible with the research question posed in the research study because the specific topic, transition into Aotearoa nursing practice, had been experienced by all the participants. By considering the beliefs, values, and practices used by the IQN research participants, a picture of the social construction of nursing culture by IQNs within the Aotearoa nursing culture was interpreted and described (Cruz & Higginbottom, 2013). The relevance of prior learnings from the CAP course and how these have shaped current nursing practice are articulated and critiqued in Chapter 8 of the thesis. An opportunity for the researcher to review and critique the participants'' descriptions of the content of the CAP course was also provided, allowing for formulation of the recommendations for suggested changes to the CAP pathway offered in Chapter 9 . Focused ethnography, therefore, supported the provision of a picture of the social construction of nursing culture by IQNs within Aotearoa professional nursing culture. This construct occurred by considering the research participants' beliefs, values, and practices; and understanding how the CAP course learning had shaped their current nursing practice.

Used in Academia as well as in the Development of Healthcare Related Services. Examination of the shared phenomenon of moving from one nursing culture to another was the specific context that defined the IQNs' assumptions about their life and work (Crotty, 1998). The use of focused ethnography methodology was supported by the growing recognition of this type of research to identify the studies of nursing practice as a cultural phenomenon (Higginbottom, 2011). Parallels have been identified between the use of the nursing process and ethnography as the skills required for observation of people, listening skills, interpretation of the assessment, and reflection of the situation to deconstruct and reconstruct the experience (Roper & Shapira, 2000). In this study, the focus on the participants' perceptions about their experience of the current process for IQNs to obtain nursing registration in Aotearoa has provided significant information

regarding the experience for the participants. This information may have implications for the future development of the registration process.

Conceptual Orientation of a Single Researcher. In this way, the researcher of another culture must acknowledge that they are also a part of the process. For example, viewing another culture occurs when we observe it through the 'lens' of our own cultural vision; and, therefore, it cannot be without its bias. Additionally, reliable observations and reporting should occur without ethnocentrism, the concept that our culture is better than another (Cook & Brunton, 2018). Choosing to interpret without preconceived bias should reduce the chance of prejudices when we impose our view on others through a dislike of what we fear. However, it is impossible to have a non-biased interpretation of another culture as each researcher must consider and contend with their own knowledge and life experiences. Therefore, in order to minimise researcher bias, and as discussed in Chapter 7, I consulted with my supervisors regularly to discuss my interpretations and thoughts around my analysis of the data (Kumar, 2011).

Participants Usually Hold Specific Knowledge. For this research, when considering the investigation of a particular cultural aspect, the professional role of a nurse, I also considered the inherent cultural influences on the person being approached when asking about their work habits and beliefs. In this instance, I was aware that researching IQNs working in a host country's workforce would provide results based on a synergy between their personal interaction and their professional roles. As a result, I would be able to have glimpses into their social constructs of values, beliefs, and reality. In addition, this interaction may give me the means to see how specific actions occur (i.e., nursing tasks), and can help relate it to the situation in the inherent cultural community in which it takes place.

Problem-focused and Context-specific. In Aotearoa, nursing competency is equally focused on te Tiriti O Waitangi, cultural safety, clinical skills, and knowledge of the legal implications impacting service provision (NCNZ, 2008). Nurses must develop an understanding of culture, both their own and their patients, to provide culturally competent and safe care as defined by the patients and not the service provider (NCNZ, 2008). Identifying how IQNs, coming from different cultures, had integrated Aotearoa health beliefs and practices into their professional, personal, and interpersonal lives through a focused ethnography has provided insights into future planning for IQN competency assessment (Wall, 2015).

Episodic Participation Observation. Focused ethnography can include observing the researched people, environment, or situation (Aamodt, 1982). However, in this study, the research aim and questions around participants' perceptions of a past event, the CAP, prohibited options to observe participants in the field. Nevertheless, journal notes were made immediately following each acceptance of the invitation to participate and detailed the participants' demeanour during the interview. These observations are included in the discussion of the findings in Chapter 8. In a focused ethnography an inductive analysis, with the use of a thematic analysis framework, uses multiple readings and re-readings of the detailed raw transcribed narrative data to focus on similarities in the transcribed data to enable the researcher to derive emergent themes that can inform meanings or descriptions for categorisation (Stuckey, 2015; Thomas, 2006). The discovery of significant cultural beliefs and practices can then be investigated after a process of coding, sorting, identification, generalisation, and reflexivity (Higginbottom et al., 2013; Stuckey, 2015).

Method

Recruitment

A poster inviting participants was developed that specified the recruitment of IQNs from the Philippines and India who had completed a CAP course in Aotearoa (Appendix B). The poster was placed in clinical areas in aged care facilities and the local DHB hospitals. It contained details of the criteria for inclusion in the study and contact details for the researcher. Posters were time-limited for two weeks on the hospital notice boards by the DHB rulings on poster billing and remained in place for several months in the aged care facilities. Initial responses to the posters were limited and most participants were recruited following word of mouth referrals which did not appear to influence the sample size for the research.

Sampling criteria

Purposive sampling by cultural grouping (Parahoo, 2014) was used to seek participants of key demographic of interest who would provide the required information related to the research concept and questions (Crotty, 1998). The participants groups were IQNs from the Philippines and India, as outlined to be the largest ethnic demographics of IQNs in chapter two.

Rationale for Sample Participants

As most IQNs registering as nurses in Aotearoa are Filipino or Indian (NCNZ, 2019), participants were purposively recruited from these two ethnicities. Accordingly, the Philippines and India are the most common country of origin of participants in the CAP programmes nationwide (NCNZ, 2019). Another criterion required the participants to have two years post nursing registration in Aotearoa. This principle ensured that they had time to transition into their RN role and reflect on and determine any experiences that may have been relevant to the research questions. In addition, the researcher had been providing CAP courses in the Northland area for two years, and any previous students who had completed the course under that tuition may have felt obliged to give a positive biased report of their learnings. See Table 2 for a summary of participant selection criteria.

Table 2. *Selection criteria*

Inclusion criteria
1. IQNs with Aotearoa RN registration
2. Two or more years post completion of CAP
3. Working in the upper North Island of Aotearoa
4. Primary RN registration in the Philippines or India
5. Ability to provide informed consent to participate in the study
Exclusion criteria
1. IQNs working as healthcare assistants who have not completed a CAP
2. IQNs who achieved a nursing degree in Aotearoa
3. Previous CAP students of the researcher
4. People who are known to the researcher in a personal/professional capacity

Recruiting and Approaching Participants

Initially, IQNs who met the sampling criteria were identified through professional networks in Northland, Aotearoa, via aged residential care facilities and the local DHB. Next, posters and information requesting participation in the study were printed in July 2018 (Appendices B & C) and circulated via professional leaders in the nursing network of the Northland area or pinned to information boards in professional areas. However, initially only a few participants responded to the poster. Fortunately, they were able to be included in the research study as they met the criteria. Unfortunately, attendance at locality nurses' management meetings in nursing networks to present the study did not elicit further responses from prospective participants. Therefore, in August 2018, the recruitment sampling shifted to the use of 'snowballing' (Heckathorn, 2011; Parahoo, 2014), where further participants were recruited by word of mouth and suggestion of inclusion by initial participants in the study and networks from student cohorts. Recruitment then became more robust with several requests for inclusion in the research study. In addition, several applicants for participation intimated they had 'a lot to talk about' regarding the CAP course, which engendered some anticipation for the researcher.

The first participant noted the placing of the poster and, after discussion, agreed to be considered for an interview. Another participant responded to the research flyer posted in the hospital setting, and another replied via a hospital colleague's suggestion. Due to limited responses, the administrator of a Facebook page for Filipino nurses in Aotearoa was

approached, and permission was granted to display the poster online. This internet advertisement of the research prompted responses from two Filipino nurses from Auckland, who both worked in hospitals in acute care settings. A few participants were recruited from Northland via response to the hospital and aged care posters. Other participants were recruited via word of mouth from colleagues of known CAP students. No participants withdrew from the research study after reading the information, participating in the interview, or at the end of the interview process. Finally, all participants confirmed that they undertook their CAP courses in various institutions with North and South Island providers in Aotearoa.

During the selection and interview process, it was noted how seemingly confident they were with their use of English. In addition, the questions and discussions used during the interview appeared to be easily understood by each participant, and there were minimal requests for further explanation of the language used. One explanation is that modification of the questions and interviewer responses in the first pilot interviews occurred following terminology clarification. Although participants' understanding of the process and the questions was a possible challenge identified in the research design, due to English not being their primary language, evidence of their ability to comprehend the questions was assumed due to the requirements for acceptance onto the CAP course. Following a short explanation of the interview process and the research aim, the participants all stated they understood and were happy to continue with the interview. Furthermore, my acknowledgement of the participant's understanding of the language and nursing terminology allowed me to commence the interviews confidently.

Ethical Considerations

Ethical implications were considered before the research was approved, and approval was sought and obtained from the Auckland University of Technology (AUT) Ethics Committee (Appendix D) on 17 September 2018, (code 18/328). As an RN and professional nursing educator, I adhered to the NCNZ's (2012) Code of Conduct, a guide to nurses' behaviour in professional practice. Additionally, consideration of participants' possible cultural perceptions of the researcher's role as an educator and hierarchical power holder arose and were met with plans for full discussion and written information provision about the research prior to inclusion. Finally, to ensure the participants' autonomy, they were given the choice of the venue for the interview and withdrawing from the study at any point. In addition, participants were assured that their contributions would be confidential by way of

secure storage of recorded data and that their identity would be kept private. Use of a brief demographic data sheet to log participants' age, ethnicity, location, area of work, years of work, and where CAP had been undertaken was employed to ascertain statistics for possible further future enquiry into the deployment of IQNs after RN registration (Appendix E). Assurance was given that this form, the recordings, and transcripts of data from the interview would remain in a secure location for five years and would be destroyed at that point if no longer required for research purposes. Following agreement from each participant, forms for informed consent (Appendix F) were completed at the commencement of each interview.

The consent form contained places for participants to state they had understood the information provided about the research, the process of the interview, the information that the interview would be recorded, the choice to withdraw from the research at any time, and, finally, space for a signature and contact details. Informed consent was deemed to have been given when the information sheet was read, understood by the participant, and following time for answers to possible questions (Parahoo, 2014). Participants were allocated a pseudonym to ensure privacy for the study as promised. The use of pseudonyms reassured the participants that the information obtained would be confidential and, therefore, they would not be identified in situations where they may provide sensitive information. Pseudonyms also allowed for essential identification by the researcher and professional transcriber of each different speaker and the transcript of their interview.

Demographic Data

Over nine months, 12 nurses from the Northland and Auckland areas of Aotearoa responded to the invitation to participate in the study. There were eight Filipino respondents, of which six were female and two males. A total of four Indian participants responded, of which two were male and two females. Of those, six worked in aged care settings and six in hospital settings. Participants were aged between 26 and 50 years. The length of time worked as an RN in Aotearoa ranged from 2 to 20 years, and country of their first RN registration was identified as either India or the Philippines (see Table 3 for further details).

Table 3.

Key demographics of participants

Participants (Pseudonyms)	Age	Origin of nurse registration	Years as NZRN	Current workplace
Jacob (m)	26-30	India	6-10	Aged care
Anu (f)	31-35	India	6-10	PACU DHB
Sarah (f)	31-35	Philippines	1-5	Surgical DHB
Joy (f)	31-35	Philippines	6-10	HDU DHB
Sijoy (m)	26-30	India	6-10	Aged care
Maria (f)	46-50	Philippines	16-20	Renal DHB
Aiko (f)	26-30	Philippines	1-5	Aged care
Michaela (f)	31-35	Philippines	1-5	Aged care
Deena (f)	31-35	India	6-10	Aged care
Py (m)	31-35	Philippines	1-5	Aged care
Lucy (f)	36-40	Philippines	6-10	Renal DHB
Joseph (m)	31-35	Philippines	6-10	Surgical Theatres (private)

Data Collection

Development of Semi-structured Interview Guide. A semi-structured interview guide (Appendix G) was developed from the previously reviewed literature (Chapter 5) and provided a guiding list of semi-structured questions. This format supported in-depth discussion during the interviews.

Piloting the interview guide. An initial two pilot interviews were conducted, and the resultant recording and transcripts were reviewed to critique the process and better format questions for subsequent participants to respond to as initially the flow had not been consistent. The initial questions, as detailed below, were used in the pilot interviews

Can you tell me a bit about yourself and your everyday work as an RN?

- Please tell me about your experience of undertaking the CAP course.
- Did your practice change since completing your CAP course?
- How does your professional practice in respect to applying cultural care delivery differ now from that in your country of origin?

- Can you tell me some stories about how the clinical practice component covered in the CAP provided you with an understanding of:
    - Clinical responsibility
    - Accountability and decision making
    - Assessment skills required in New Zealand healthcare planning
- How did the cultural safety component in the CAP course prepare you for working in New Zealand?
    - How did it feel to have to adjust to different cultural groupings of patients?
    - How well do you feel you understand and apply the Treaty of Waitangi in your current nursing service provision?
    - Can you give me some examples from your work that you can relate to applying your knowledge of the cultural safety component of the CAP course?

The questions when piloted had too much emphasis on the participant's current work in their RN role. In addition, the appeared to be the wrong order, making the interview responses challenging to manage. After reviewing the interview recording and transcription of the data, the questions and their order were revised to give a better flow and more logical interpretation. Additionally, the use of the word 'stories' appeared to indicate to the participants that the information about to be given was not true. Therefore, it was noted that although this word is commonly used in my cultural home environment is not a common word used professionally to elicit responses when asking for narrative evidence. The prompt sheet was modified, and the new order of questions provided a better flow with more information provided by the participants.

Inclusion of support prompts to provide examples of work situations or understanding of nursing practice was included in questions such as

- Can you give me an example of how you……?
- Is there anything else you would like to tell me about ……?

Finally, discussions were held with my research supervisors to discuss modification changes and how this could affect the information obtained for analysis of the recorded data.

Approach

Participants were given the option of face-to-face meetings in a setting of their choosing, such as a room at the university campus.

Setting. The choice of interview setting was given to the participant to support neutral, comfortable, friendly, and private areas. The settings chosen for the interviews varied from participants' own home, a cafeteria, or a room at their workplace. This choice enabled the participants to control part of the interview process. A rapport was then established by holding a discussion of the research aims and process in an environment conducive to holding an interview (O'Reilly, 2009).

The choice of attending focus groups or individual interviews was initially offered only to the first few respondents. Following this offer, it was noted that the first three respondents preferred a face-to-face interview. However, further discussion with the participants as to why this was their preference identified that a focus group session would not be suitable for IQNs from the Philippines or Indian cultures due to perceived hierarchies from cultural values impacting their contribution to discussions in a group setting. Therefore, individual interviews were chosen as the preferred method of data collection from the participants for gathering vital information.

Throughout the study, semi-structured interviews were used to drive the research data collection and translate concepts and ideas (Parahoo, 2014). The use of indicative open-ended questions in a semi-structured format gives the interviewer scope to allow the participant to continue talking about a subject without feeling they must stick to a specific topic. It supports the addition of unexpected but important information that may be relevant to the data without limiting the answer (Crotty, 1998). For example, the participants in this research were able to expand on initial responses with encouragement by using meaningful body language, such as nodding and words such as 'ok', in keeping with the premise of a focused ethnography.

The focus of the data collection was to obtain enough material to derive what is described as 'thick description' (Al-Saggaf & Williamson, 2006; Geertz, 2017) or a large amount of narrative data to give enough information for analysis. In addition, field notes were taken during and immediately after the sessions and were used to identify speakers and critical ideas as they presented. Data saturation was deemed to have been attained for this research study after 12 participants were interviewed (Parahoo, 2014).

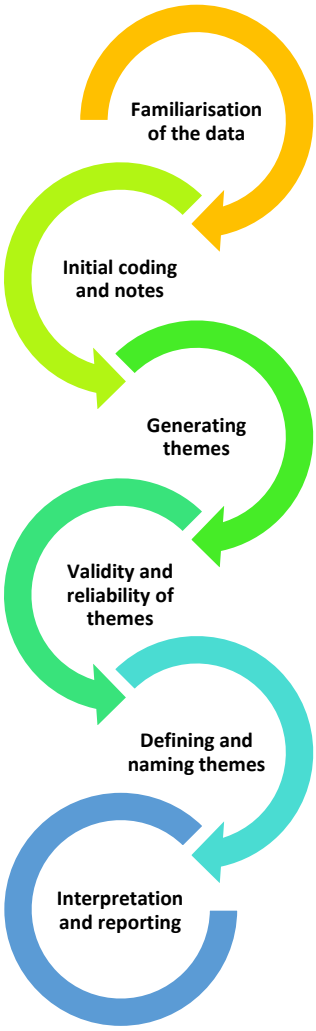
Data Capture. In order to capture the data required for analysis, all interviews were recorded on a digital recording device. A second device, an iPhone, was used as a backup. The second recording was deleted as soon as the recording on the nominated device was confirmed as usable. Next, following successful recording and entry onto a digital sharing platform, the saved data were sent electronically via Dropbox, a cloud online data storage facility, to an externally sourced transcription professional. The transcriber signed a confidentiality form to confirm that they would not divulge any information about the participants (Appendix H). This confirmation further supported the provision of privacy and confidentiality for the participants. Next, the recorded data were checked for quality and accuracy of the transcriptions by reading the text whilst listening to the interview recording. Data coding of the interview recordings began with the data from the first three interviews. Changes to the interview guide and questions occurred following this analysis due to my supervisors and me agreeing that the changes would provide better data. Coding continued after 10 interviews and on completion of the final interview. Interview recordings were sent for transcription at the end of each interview—this process allowed for the transcriber to return them for analysis in a prompt manner.

Thematic Analysis

Braun and Clarke's (2014) six-phase process of thematic analysis coding (see Figure 5) was used throughout, generating initial themes and patterns so that definitions and a more coded themed analysis were identified. Breaking up the data into categories like this allowed for grouping similar, manageable parts that were further defined as 'themes' (O'Reilly, 2009). Using a software programme, NVivo, to record and assist classification of the data was considered and attempted. However, it was challenging to learn the software and use the programme whilst also coding and sorting the themes. Therefore, manual sorting of the previously selected data was carried out as the data were more easily identified when written on small notes that could be moved around.

Figure 5.

Coding process following Braun and Clarke's (2021) thematic analysis



Familiarisation of the Data and Initial Coding. The sorting and procedure for identifying the codes and themes involved ordering and organising the collected data from each individual interview, reading it repeatedly, searching for meaningful words or phrases, labelling them into codes, and reviewing it. This method of initial coding can also be described as a reflexive approach where the researcher creates the themes through the reading and re-reading of the data to identify and consider patterns and construct themes. This process is described by Braun and Clarke (2021) who stated that "themes cannot exist separately from the researcher – the are generated by the researcher through data engagement" (p. 39).

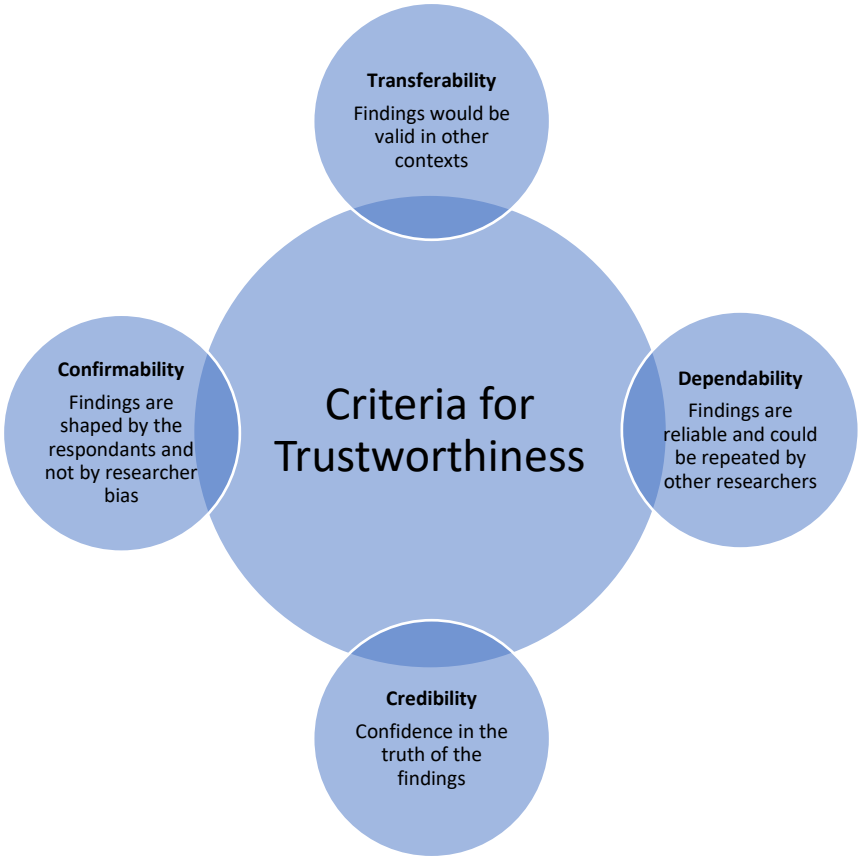
In addition to reading the transcribed data on the text sheets, recordings were played for review, and written notes were added in each sheet margin to aid my thoughts on the participants' responses. This process allowed me to note any pauses or exclamations that were not represented in the written words (De Chesnay, 2015). Next, the data text sheet was examined line by line and noted phrases of interest were logged. Finally, these phrases or sentences were noted on post-it notes and placed onto large sheets of paper (Appendix I).

Generating, Defining and Naming Themes. Headings were written at the top of large sheets of paper to allow for grouping of the codes to create sub-themes, and I was then able to further sort the sub-themes into groups using my interpretation of the written words and phrases. This process supported the generating of overarching themes as it was possible to see quotes and groupings, sort and re-sort them, and see how themes formed from the data (Lainson et al., 2019). Furthermore, as discussed in Chapter 3, I considered my possible bias and assumptions of the participants' cultural backgrounds when considering the data and sorting it into themes. In addition, examples from my written journal notes for each interview participant were considered to support the choice of codes and themes. This process enabled an overview of the quotes and exemplars to formulate and name groupings of similar data sets. Using this process of thematic analysis (Clarke & Braun, 2017) supported me to see the recurrent themes that arose from the data rather than seek predetermined contexts. The identified groupings were then entered written on a whiteboard for better visualisation (see Appendix J) and finally transcribed onto an Excel spreadsheet under names of the overarching themes to share the information with my research supervisors for discussion and identification.

Rigour

Rigour in qualitative research is understood to be the trustworthiness of the research process relating to the authenticity and transferability of its findings (Cohen & Crabtree, 2006; Lincoln & Guba, 1985). As illustrated in Figure 6, there are four means by which trustworthiness can be shown.

Figure 6. *Adaptation of Lincoln & Guba's (1985) criteria for trustworthiness*



Transferability and Dependability

Trustworthiness in respect of transferability of the findings of this research study is illustrated by the use of an appropriately defined research methodology, participant sampling, and data analysis concurrent with the recorded data elicited in each interview. In regard to this research study, I shared the methodology, and my proposed methods of obtaining data with the supporting university's research and ethics committee, and my research supervisors who approved and supported my approach. Equally, I consulted the supervisors at each stage of the process and shared my findings, results, and interpretations from my thematic analysis of the data for a full discussion (Kumar, 2011). I have outlined the research study process, steps undertaken, and its findings in this Chapter and in Chapter 7.

However, in focused ethnography, a study's generalisability to other research studies as a sign of validity is not the primary concern. Furthermore, the qualitative nature of the research means it cannot be duplicated as it does not have objective measurements such as statistics or numerical analysis (Crotty, 1998). Instead, the information gained from the data is determined to be rich in insights into how the participants perceive the subject discussed

(Chuang & Abbey, 2011; Geertz, 2017; O'Brien, 2007). Detailed data from the ethnographic interviews in this research provided rich information in what is also known as 'thick description' (Lincoln & Guba, 1985). It comprised large amounts of text for coding. Equally, the participants' data provided a broad range of information for interpretation and analysis, as evidenced in the findings and discussion Chapters 7 and 8. Finally, these findings and resultant analysis were shared with the researcher's supervisors in the process of peer debriefing, where aspects of the interpretations were discussed and modified as appropriate (Lincoln & Guba, 1985).

Confirmability

Undertaking this research using a naturalistic paradigm and the techniques and criteria to explain and maintain trustworthiness and authenticity, as Lincoln and Guba (1985) suggested, allowed for the more inductive and creative process of investigating the recorded data (Roper & Shapira, 2000). This paradigm allowed me to assign meanings to the data provided by the participants of how they perceived the world around them; in this instance, how the IQNs perceived the CAP course had either benefited them or not. Using these criteria, authenticity in this research study has been achieved by showing excerpts from the data and the means used to code the data to the peer reviewers, the doctoral supervisors. They then assisted the interpretation by discussing their independent views of how the themes from the interview data were obtained (Higginbottom et al., 2013). Furthermore, the concept of researcher bias was considered in discussions around the possible assumptions around contextual groupings of the themes and sub-themes to foster reflexivity. As a result, the introduction chapter includes statements around possible biases that may have affected the interpretation of data.

Credibility

The credibility of research data, seen as a parallel to validity, can also be achieved via the use of 'member checking' of the recorded data. This process occurs when the participant reviews their interview transcript to confirm whether the theme of their conversation was correctly identified and can add any further data if desired (Cohen & Crabtree, 2006). In this study, a summary of the interview was not given to participants for verification. There was a consideration that this could lead to confusion if the participants, who had English as their second language, did not recall their initial words or disagreed with the researcher's subjective interpretation. However, as qualitative social research is, by definition, interpretive (Crotty, 1998), the use of triangulation of data sources from different

participants by recording any non-verbal observations and constant review of the data by the researcher served to validate the initial interpretation. Additionally, triangulation provided further credibility by showing how the same themes in the data were identified (Cohen & Crabtree, 2006). Finally, by describing the phenomenon and responses to research recruitment in detail, using the transcripts from the participants to prove consistency in the themes, as shown in the findings in Chapter 7, and discussion around the slow responses to participate in the research, further credibility can be given to the research data.

Summary

This chapter has provided an outline of the research methods, epistemology, and ontology for the choice of focused ethnography as a methodology for this study. Furthermore, it described sampling, recruitment processes, and the rationale for choosing the sample population of IQNs from the Philippines and India who had completed a CAP course to obtain Aotearoa RN registration. Finally, the thematic data analysis process and the methods of rigour and validity of the analysis through member checking were described. The findings from the data are presented in the following chapter and are included with further critique in both the discussion and conclusion chapters—Chapters 8 and 9—along with recommendations for future educational practice, policy, and future research.

Chapter 7 Findings

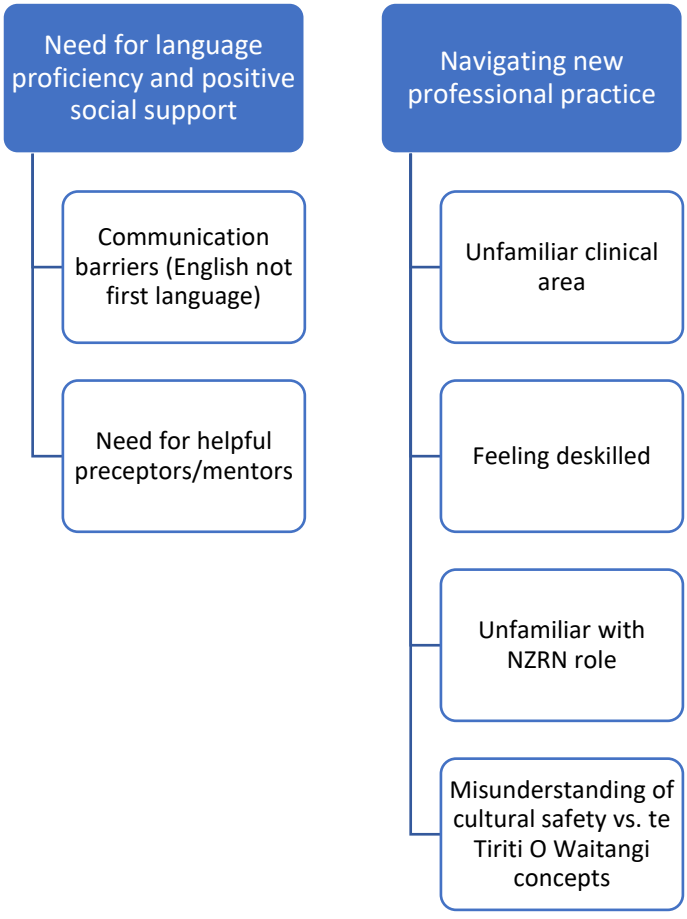
This chapter will outline the key themes arising from the analysis of data in light of the research questions. First, the testimonies from participants on clinical practice, cultural safety learnings, and the overall experience of the CAP course are grouped together and presented under the theme: the need for language proficiency and positive social support; with sub-themes of communication barriers and the need for helpful preceptor input. Second, the theme of navigating new professional practice is presented; with the sub-themes of unfamiliar clinical area, feeling deskilled, unfamiliarity with NZRNs role, and misunderstanding of cultural safety versus te Tiriti O Waitangi concepts (see Figure 7).

Quotes are taken verbatim from the interview data and are presented to provide a rich, in-depth contextual understanding of the participants and their perceptions of the interview questions and their experiences while undertaking the CAP course.

Overview of Themes and Sub-themes

Figure 7.

Research data themes and sub-themes



Need for Language Proficiency and Positive Social Support

The participants' experiences relating to their perceptions of social support were mainly centred around the language and communication issues they had faced and descriptions of their professional support network. All of the participants had English as a second or tertiary language. The ability to understand the colloquial accent and ordinarily familiar words is presented more socially as it relates to general conversations with patients and preceptors during non-complex nursing communication episodes. Next, preceptor support and how this affected the participants is detailed in respect to integration into the professional community of nursing. Finally, further instances of language and terminology issues are presented within the navigating new professional practice section as they relate the experiences of different nursing terminology and language proficiencies on professional settings.

Communication Barriers

Language differences were mentioned by several participants as a factor in their experience of the CAP course in respect of getting to know the 'Kiwi' accent. Several participants explained how the exposure to the different words, slang usage, and pronunciation had been challenging to get used to at first but became more manageable over time.

> *I appreciated the CAP in the sense that I didn't know the Kiwi accent has such a strong accent, so it helped me get used to that because back home the accent was mainly more on the American side. So, for example, in my first few weeks, some patients will be asking "can you lower the 'hid' of the 'bead'". And I was like, ah what's that?! Because you know, for us back home 'bead' is a bead for like beading and all that. So, I was like 'oh, the bed!' and also like the pen, the 'pin' and all that.* (Joy 5th year NZRN, Filipina)

This was a common theme in the responses, and Maria recalled that she had become used to asking for help if unable to understand the conversation.

> *We had one preceptor, she's very much a Kiwi person. And, I'm used to the Kiwi accent now but at that time I'm like "oh my God!, I didn't realise their accent is this strong!" But they were fine about it and if you asked them to repeat what they said, it was fine.* (Maria 17th year NZRN Filipina)

Need for Helpful Preceptors/Mentors

Preceptors were seen to have had a marked influence on the experience of doing the CAP, and most were spoken of in high regard. Many talked about how friendly and knowledgeable their preceptors had been and how thorough their support and guidance were. Adaptation to Aotearoa nursing practice was deemed the aspect given most focus by both tutors and preceptors alike, as the skills and knowledge were seen to be the same as the participant's home country. Many spoke of carrying on the preceptor's teachings in their current roles.

> *It's mainly the preceptors and the clinical tutors that I remember. Because if you feel you need to address a concern, you can tell them. Then they would discuss what your concerns are, what's bothering you. And then mainly because you're observing your preceptor, you can see how you need to work in NZ.* (Joy 5th year RNZN, Filipina)

Aiko agreed and detailed how she had found her support person to be very helpful in her CAP journey.

> *I would say the clinical placement is the biggest thing really. It helps you especially if you've got a good buddy nurse, the preceptor. Yeah, I've been blessed to have really awesome ones and I think that really counts because someone is leading you on, taking your through the road so that you don't get left behind.* (Aiko 3rd year NZRN, Filipina)

Py discussed his interactions with other IQNs, who did not have the same support as he had experienced, with a sense of sadness.

> *My preceptor was really good. I was lucky that she was structured and experienced. Seeing it from my other CAP mates, they told me the preceptors weren't consistent. Different people every week and a 'crowd mentality' because they felt like they were God. They didn't seem to want to do it or they just didn't care, you know. I think it depends on where you are placed and who you are with. Because it was a critical thing for me, new to NZ, new to nursing in NZ and it's good to have a good example to follow.* (Py 5th year NZRN, Filipino)

Navigating New Professional Practice

The following section reveals the issues in meeting and transitioning into the new professional practice experienced by the participants. The selection of quotes presents pertinent data regarding the participants' clinical practice experiences. It outlines their thoughts about their clinical placement settings and how this affected their learning on the CAP course. It includes examples of their understanding of carrying out clinical assessments and clinical tasks. This information correlates with their understanding of accountability and clinical responsibility for decision-making as nurses in Aotearoa. The data will also provide examples of how the participants' cultural experiences differed from their original nurse education and prior clinical experiences.

Unfamiliar Clinical Area

Currently, there are 21 providers of the CAP course in Aotearoa, and all provide different course content under the overarching nursing council standards for the provision of competency assessment for international nurse registration (NCNZ, 2008). In addition, as discussed in Chapter 2, clinical placements occur with accredited facilities from the learning institution and nursing council.

Placement provision appeared to differ in each CAP course provider's locality. Some courses offer local aged care facilities, acute care wards within the DHB hospital, or allow a choice of student preference. Most of the clinical placements provided to the research participants were in aged care facilities. Some participants felt that this was 'sad' as they had no exposure to what they deemed 'acute clinical' settings. They expressed the thought that it would have been better to go into the DHB hospital wards as their previous experience in nursing had been in these more hospital focused clinical areas.

> *I didn't have a choice other than going to aged care facility really.* (Anu 6th year NZRN, Indian female)
>
> *When we have a competency here, we go to aged care, rest home to do the practicing.* (Sijoy 6th year NZRN, Indian male)
>
> *Because back home I usually worked in ICU but then my CAP placement is mainly focused on the rest homes.* (Joy 5th year, Filipina)

One participant had been offered a choice of finding her own placement and had chosen to do it in Auckland but could not find an acute setting.

> *They organised all the placements for us, but they did ask if anyone wanted to go to Auckland to do it. Because they weren't exactly placing us into aged care, it just ended up with most of the ones being there. But we did have somebody in our group who ended up in a neonatal unit placement which was, you know, highly specialised. A few ended up in the wards. I ended up in Timaru in the rest home hospital.* (Aiko 3rd year NZRN, Filipina)

Shifting the CAP students to unfamiliar practice areas clearly influenced their clinical task completion as some of the participants stated that they had to adjust to differences in their practice to suit their new area of work. These differences are reported and presented in the sub-themes below.

Feeling Deskilled

This section outlines the participants' perceptions of the clinical practice tasks carried out as part of the clinical practice component of the CAP course.

Just a Review. One participant reported clinical practice tasks within the placement as "being 50% the same" (Sarah 8th year NZRN, Filipina) as in their home country and were described as "using similar practices, but in different environments". One participant (Sijoy 6th year NZRN, Indian male) defined the CAP as good training in aged care nursing but having an inherent specialism in, and information about, how to work only in these areas in Aotearoa. Many participants talked of the course content as 'having had to go back to basics' and stated that they had nothing intense to do whilst on the clinical practice component. The theory content of the course in respect of clinical skills and updates were described as 'basically the same' as those they had learned in their home country. There was some frustration that their expectations had not been met as they had thought they would learn something new; instead, they found themselves relearning basics they already knew and were tasked with what they described as 'non-complex' actions.

> *I was expecting something big to learn, like when whoever is coming from a different country, they expect to like, learn something big. But what we learnt is something that is basic, that we already learned before. For them what happens is they've already trained for four years and then become head of care unit or it might be team leader or something. When they come here and they just give the medicines, I*

> *think they will be like "I'm doing nothing".* (Sijoy 6th year NZRN, Indian male)

Reports of not carrying out what were identified as RN roles and undertaking more basic clinical tasks rather than using assessment skills were a general source of frustration for participants. Although there was noted similarity in the nursing practices between their home country and Aotearoa, the consensus was that the clinical practice component was seen as an observational exercise. For example, students merely followed their preceptors and were a helping hand rather than perform a hands-on nursing role.

> *I think in my first week they made us do HCA stuff first. I think just because they wanted us to recognise what's the difference between the responsibilities of an RN from the HCA. So, like the first week it was only giving washes, showers, and all that. And then I just tagged along with my preceptor, just learning the techniques of how you give medications to demented patients.* (Joy 5th year NZRN, Filipina)

Aiko recalled that:

> *They only had us brush up on the abdominal bit, but there was mostly a demonstration of other skills like wound dressings, urinary catheters, sort of thing.* (Aiko 3rd year NZRN, Filipina)

In recounting his description of his experience during the clinical practice component of the course, one participant paused to reflect on his thoughts, then gave a deep sigh before stating,

> *But then yeah, you feel accomplished in a way because you worked hard to be there but as I said, we just had to review skills and all. I know it was just a review because we've done that all our lives and you know we've been trained for that for a while.* (Py 5th year NZRN, Filipino)

Already RN in Other Countries. Participants expressed their disappointment in not having their previous nursing experience acknowledged, which appeared to be a common occurrence. For example, during their interview many of the participants talked about how they had already completed a four-year degree in nursing in their home country. Of note is that this information was offered when it was not requested, as it indicated how they felt

about having had to undertake a two- to three-month-long course to obtain nursing registration in Aotearoa.

> *For me it was fine, I already worked for one year in NZ. But in India, I worked in psychiatry, gynaecology, urology, neural, in every area and I have that experience of four years. We also learnt pharmacology, we have the same curriculum for the doctors and nurses so learn most of the things. So, when it comes to being here, after doing four years, three months of competency it's nothing for us. I still remember all they asked me to do was check the vitals. So, my thought at the time was 'why are we paying $9000 to do a 2 month or six-week course when we already learnt that spending the same amount in India for four years?* (Joseph 7th year NZRN, Indian)

Lucy further discussed the length and content:

> *The BN course here is only three years, and we've done four years in the Philippines. It's very hard there, very strict. But it [CAP course] was like going back to how I was being a student. It was too much actually for a span of two months. It's like, we're already nurses and we already have our licences back home, but then they need to check if we're capable of becoming registered here in NZ. And, yeah, it's humbling.* (Lucy 5th year NZRN, Filipina)

Several participants felt aggravated about this fact, but Sijoy relayed his feelings succinctly.

> *Personally, I feel I worked 11 years to earn NZ competency.* (Sijoy 6th year NZRN, Indian)

Prohibited from Using Prior Technical Skills/No Acknowledgement of Prior Training or Experience. Other participants were also frustrated that their previous clinical practice experience had not been recognised when undertaking the CAP course, describing how they were not allowed to carry out tasks or skills that they gained in their initial nurse training. Examples of the differences in clinical practice were given.

> *There is a limitation in the nursing practice. We can only do certain things like, as I said, IV we can't do. So many things we can't do in the*

> *aged care, we need to take them [patients] to the hospital.* (Deena 7th year NZRN, Indian)

Py completed his CAP clinical placement in aged care and expressed his dismay at the lack of acknowledgement of his skills and experience. He described how he felt despondent when comparing his placement to his fellow CAP students. He talked of having fewer interactions with different people and how this led to him feeling inactive in his learning on the CAP.

> *Clinical skills are clinical skills here. Aged care setting was different from what I'm used to, and the clinical care is pretty much limited compared to being in an acute clinical setting. And you tend to be doing the same things almost every day, and you feel like you're not growing. And you do feel that when you are with your peers or other clinical colleagues who have been working in the hospital that you know you are clinically knowledgeable about different things, yeah. You feel like your stagnant when you're in aged care.* (Py 5th year NZRN, Filipino)

However, not all the participants felt that they were deskilled, and Michaela noted that she was carrying out practices that she had not encountered previously. She explained how she had no previous experience using a particular piece of equipment and rationalised it by explaining why it was so.

> *Using the Niki pump. In the Philippines, it is a Catholic country, 90% are Christians and then we are usually pro-life, and even the doctors don't prescribe syringe drivers or morphine. It's a very big question mark if you use it, but here it's widely used.* (Michaela 3rd year NZRN, Filipina)

Sarah, too, found it difficult to adjust to the changes in practice and recalled this in an embarrassed manner. She stated that she still found it humbling to think of how she used to work in the Philippines and how backward she felt the system there to have been.

> *When it comes to practice, it's a little bit the same but there's a few things that my charge nurse would tell me "Oh that's no longer done here in NZ. We did that 20 years ago but we're no longer doing those things". But I remember that we're still doing that in the Philippines, so I think that's one thing that I had to adjust, and sometimes I can't stop comparing how we do things in the Philippines. Like, in a surgical ward*

> *here we have a pathway for patients who have little to no co-morbidity so that we enhance recovery. The protocol is on the first day after surgery, after a few hours when their legs are no longer numb, they should stand up, start mobilising and instead of putting them nil by mouth until they start passing wind, they start on a food diet. It was a bit of a shock for me because I thought that it was not useful for patients but then that's the practice here. And they've done lots of studies like research about it and it did work. It's hard to do something that you don't believe in but I just tried to talk to myself, like, you're in a different country now, they have a different culture, they've done studies, so I have to, you know, get on board.* (Sarah 8th year NZRN, Filipina)

The discomfort of the above participants in moving from their familiar clinical areas to an entirely new area for the CAP was notable. In addition, feelings of frustration highlighted their realisations that the skills and experience they had gained previously were neither acknowledged nor utilised during the course.

In contrast, was information obtained from those participants *not* in aged care clinical placements for the CAP course. Minimal changes in their clinical practice were outlined, and no difficulties were identified in exposure to different nursing practices to that of their home country. Those with placements in acute nursing settings gave examples that were presented as mirroring their previous clinical roles.

Joseph suggested that the main differences he had experienced had been with the language and equipment names, not in his undertaken procedures. However, his CAP placement in surgical theatres was described as having been a familiar role for him. He spoke mainly of having to learn the different words and colloquialisms and how this shaped his preparation for working in Aotearoa.

> *Well, I think that theatre is theatre, that's not changed. The Philippines is so American so there are a lot of things like what we call instruments, and the things that we used there are all American based including textbooks. So, it could be as simple as an approach to something that it's based on. In NZ it's done differently, or we call the equipment different. It has the same use here, but it's called differently. In terms of practice, it's just how we talk here, but none of them violates any principles or*

> *sterility or anything. This is how things are done differently.* (Joseph 7th year NZRN, Filipino)

Lucy spoke of her CAP clinical in a renal dialysis unit. She explained how she was able to use clinical practice similar to what she had done in her home country. She stated that she felt confident there and easily identified how she had adjusted some minor areas of theory to inform her assessment and practical skills.

> *If you have more experience back home, I think it's easy to adjust to the new workplace because you have basic knowledge. And I think in general like assessment stuff, or doing care plans, they're almost the same. Apart from, for example, the parameters. Like, there's a difference for the parameters when doing vital signs, yeah, just a slight difference. But it's just a matter of critical thinking or practical reasoning. But during my CAP experience as a student, we have guided outlines to be done, and now as a registered nurse we do independent nursing actions.* (Lucy 5th year NZRN, Filipina)

There was a clear perception of the difference in clinical practice whilst on the CAP course as opposed to their practice as RNs following completion. All participants referred to themselves as 'students' whilst on the CAP and frequently spoke of working under the supervision of their preceptor for undertaking clinical tasks, of following the lead of the RN on duty, or following the tasks laid down for the course completion. The participants were asked to clarify their descriptions of *not* having responsibility whilst on the course and then relate it to their current practice. Additionally, they were asked to confirm how their knowledge and understanding of clinical responsibility and accountability as an RN in Aotearoa, was gained on the CAP. In response, they were keen to point out that they felt these definitions were the same in their home country and that there were only minor differences in the Aotearoa nursing workforce.

Unfamiliarity with NZRN Role

The following quotes present the participants' comprehension of the differences in accountability for decision-making. Additionally, it presents their impressions of the overall responsibility of the role of an RN in Aotearoa as compared to their home country. As previously, the contextual differences between the Aotearoa nursing culture and that of

the Filipino and Indian nursing cultures will provide insight into how the transitions to working in Aotearoa were provided and perceived by the students during the CAP course.

Same Responsibilities/More Resources in Aotearoa. Participants reported that they had received teaching on the CAP course curriculum about RN accountability for their practice. However, several participants did not recall what this had been or the context in which it had been delivered. Explanations of having been given pamphlets and books on accountability and decision-making were given. However, many participants stated that they had not received much help with this subject throughout the course. For example, one participant stated that they had had a 'big session' on ethics and the law and was able to talk of the '10 rights' of patients but could not give a specific example of a time when he had used this. Another responded that they too had a 'Code of Conduct' for nurses in India that was very similar to that in Aotearoa. Some examples were proffered of having the responsibility of determination to choose wound dressings and when to call patients' relatives. However, the responses did not show the importance of the CAP teachings to this accountability.

Sijoy, explained that he only began to make decisions after starting his first nursing role in Aotearoa as he got to know about the policies and procedures of the new workplace. He stated:

> *On the CAP I hardly made any decisions because we had a RN with us.* (Sijoy 6th year NZRN, Indian)

On placement in a renal unit for the CAP, Lucy stated that even at the end of the clinical placement period, she was still working side-by-side with her preceptor and had always passed her findings to her and followed her decisions.

> *In CAP course for example, I just made decisions for practical things. But for example, if the blood pressure [of a patient] is low then we need to report that one. For example, if I have my preceptor with me then I will tell her or him that's the case.* (Lucy 5th year NZRN, Filipina)

In contrast, Michaela described how she saw the change in her application of accountability from her home country to working in Aotearoa. She spoke of being grateful to have had the opportunity to learn about accountability and be allowed to practice it prior to finding a job on completion of the course.

> *We have more accountability here in NZ compared to when I was working in the Philippines. Yeah, I think that it's a big difference really because we just work in the Philippines, we just work; give medications, do the cares, do this do that but we don't usually think of accountability. But here now that I was working it's more of, like, you are on the floor, you are accountable for all your residents, 65 residents and everything that's going to happen and everything that the caregiver asks you. So, by the third week I was already confident to run the floor and the nurse in charge with me in that rest home gave me the feeling that I am accountable for the work that I've done. So, with the medications as well as the decisions I make when dealing with the people and the families, so yeah, it was helpful.* (Michaela 3rd year NZRN, Filipina)

Joseph was not so convinced when he gave his viewpoint on the differences in accountability and how he saw no difference in the two countries situations.

> *In terms of nursing in the Philippines, it really depends where you work. Like if you're working in a hospital that has training staff, so that they have more junior staff, it's like how the DHB here would work, then you have more resources, so the accountability just goes straight away to the particular person. But if you're working in the private setting then you don't have those junior staff. The accountability falls with the nurse themselves.* (Joseph 7th year NZRN, Filipino)

Describing specific examples to show her understanding of the differences in accountability between her original training and the information given on the CAP course, Sarah outlined the process for accountability in medication administration errors as an example of how she perceived the differences between Aotearoa and her prior workplaces.

> *I remember my tutor told me that she's heard a lot of stories in the Philippines where if you make a mistake you might lose your job or be under probation for a little while. But she told me here in NZ it is accepted that there is a possibility that you will make mistakes. What's important is to be honest with it, you document it properly and not keep repeating the same mistake. I remember in the Philippines, there was a colleague who prepared insulin and you know how small the insulin syringes are, and instead of putting six units, she put like 60 units and*

> *the supervisor saw it and I think they ended her employment after six months. So, they kind of like making a list of all the things that you do wrong.* (Sarah 8th year NZRN, Filipina)

Understanding the responsibility of nurses' decision-making and planning care was seen as being greatly different from how the participants had worked prior to the CAP in their home countries. The lack of support from medical colleagues in their home country was noted to be a vital component in the change experienced. The resulting autonomy in decision making was spoken of in terms of the realisation of having a bigger responsibility for RNs after completing the CAP.

> *When I worked in the ward before the CAP, we pretty much had doctors there 24 hours, so we had someone there all the time for questions or decision making. But when I came to aged care it was quite new. In terms of making decisions, the competency course helped us because we get trained by the preceptors and they gave us good information to make decisions on your own. You're all by yourself in the night shift and you have 90 residents and you're the only RN there and then you have to make quite a pressured judgement at some point you know.* (Jacob 10th year NZRN, Indian)

> *Another thing is the responsibility of the nurses. Here it is different from there [India]. You know in aged care we are working alone. When I started, I was doing team shift. I was a RN, but we can contact the clinical manager if needed. So, the responsibility comes on me you know? That's a different thing, and we don't have any 24-hour doctors here, like in hospital. In the clinical side [of the CAP] I came to know this, but I didn't really experience it because I was working only as a RN under supervision. Allocation and delegation of work sometimes was a bit hard to handle the caregivers. Because sometimes they won't do instructions. And sometimes, it's a bit difficult because finally the RN is responsible.* (Deena 7th year NZRN, Indian)

NZRNs Have a 'Big Voice' and Input. Descriptions of experiences from the CAP clinical placement around responsibility provoked a sense of awe and disbelief from several participants. The difference in staffing and the subsequent power balance change was evident as being the main cause. In addition, many communicated their awareness of

differences in the professional hierarchy in workplace, and voiced discomfort at how they dealt with them.

> *It's much different. So, here the RN gets a big importance. You have a voice here. You can decide on things, you can actually correct doctors and yeah, that voice that you have is big that we don't have in India. There, they tell us what to do and we do what they tell, you know? So that was a power change you should say.* (Anu 6th year NZRN, Indian)

Doctors 'At Home' Not Questioned, - Are Revered - Almost Worshipped. Other participants commented on their perceptions of the power change and spoke of where they found it to be most apparent, as well as most uncomfortable.

> *I think probably when we were doing the doctors rounds. That was new to me because I could see that my preceptor was questioning the doctor. It was helpful for me, you know, that helped a lot because I didn't realise that you don't need to call them 'Dr', you can call them by their first name. It was a big thing for me because you can't do that, that's a big no. We don't do that. You respect them and you worship them in the Philippines.* (Py 5th year NZRN, Filipino)

> *In the Philippines nurses are looked at as very much lower than the doctors. Here in NZ, we're just the same. If you're a doctor and I'm a nurse, we're just human beings, we're equals. In the Philippines we get shouted at, we get yelled at. You have to follow orders because you're a nurse. So, we have that high respect to doctors, and I believe we carried it here in NZ. I was even talked to by a doctor and he was very pleased how Filipino nurses interact with doctors, how respectful we are. Because we treat doctors in a hospital setting in the Philippines as gods.* (Michaela 3rd year NZRN, Filipina)

Joy defined how long it had taken her to get used to the power balance shift and how her CAP course experience had given her a good preparation for the responsibility knowledge and how to work with other staff.

> *And then even with the doctors, sometimes at the start I felt a bit shy to step up. Just because I'm not used to calling the doctor by first name basis as well. Because even back home we call everyone 'Dr'. Mostly the*

> *doctor really just orders you what to do. Unlike here, you can ask the Registrar to insert a line for you, insert an NGT for you, make him do this, and do that. After a month I got used to it because in the CAP I was calling my preceptor by name. Although at first it was a bit, you know, I was not used to it. Even my clinical tutor and our main instructor. So, we're not used to call them by their first name so we sort of negotiated that we will call them 'Miss,' so it makes in easier.* (Joy 5th year NZRN, Filipina)

A Filipina nurse, Aiko went as far as to suggest a cultural variance in the nurses' acceptance of the power shift. She outlined her thoughts on how that looked from her perspective.

> *I would say there's a big difference between Filipino nurses and Indian nurse which I've noticed. I find Indian nurses; they really stick to the letter of everything. They've got this authority down the line, hierarchy kind of thing. Filipinos are a bit more on the casual side. Once they get friendly with their seniors, with their doctors, they'll be ok. With staff below them as well, caregivers and that. But for Indians, they seem to follow strict hard working. Close to old school nursing, where doctors dictate exactly what the nurses would do, and the nurses dictate exactly what the caregivers would do.* (Aiko 3rd year NZRN, Filipina)

Jacob considered how he related clinical responsibility to the professional and societal cultural requirements. He stated that he knew he had a responsibility to get to know the culture of where he was working in order to ensure responsibility for his nursing actions.

> *We are always responsible back in India for our registration, and we are accountable for what we do. And best practice, you know in practicing, my understanding was I had to take responsibility as coming to a new culture. We need to know the culture better and respect in terms of their values and everything.* (Jacob 10th year NZRN, Indian)

All participants acknowledged that the professional culture differed from Aotearoa to that of their own country. Further examination into how was perceived by the participants is detailed below.

Misunderstanding of Concepts of Cultural Safety in Nursing Versus Te Tiriti O Waitangi Related to Healthcare Provision

The following section offers insights into the participants' understanding of cultural care nursing provision and how this aligned with their previous professional experiences and their use of this reportedly held prior knowledge. Next, information on how participants used their knowledge and experience in their nursing practice on the CAP clinical component is presented to show how the inclusion of this topic was received and processed for their future Aotearoa nursing care provision. Finally, the participants' comments on how the culture change related to their subsequent experiences of living in multicultural Aotearoa is presented for further information.

Cultural Safety in Nursing Not a New Concept. Responses to how they had adjusted to nursing people with different cultural groupings in the clinical practice area were provided with an air of dismissiveness by some participants. Information about the cultural diversity in both the Philippines and India was delivered with almost a sense of disregard. Explanations were given showing that diversity in the cultural differences of patients was something participants felt they already had a great understanding of. In some instances, the participants offered information about how they had been required to undertake studies in a theoretical, cultural component as part of their original nurse education in their home countries. There appeared to be a sense of an inherent assumption that they already knew about the concept of cultural safety in nursing. In addition, being retaught the theory of cultural safety had not made a great impression upon them during the CAP.

> *Because I come from India, so the culture there is quite diverse. We have lots of cultures, so for me it was easy to respect other people and their values and culture. Where I lived [In India] we had all the cultures, and we knew like Muslims and Hindus and each little region has their own ways of doing things. So, for me that was not that bad. In our training in India, we have a component of culture; we had sociology as a subject at the University of Nursing.* (Jacob 10th year NZRN, Indian)

Similarly, in the Philippines, cultural diversity was reported to be a regular aspect of life. As above, the theoretical, cultural component was reported as being a mandatory content in nursing education there.

> *We have Chinese immigrants, Indian, so there's a few similarities in terms of religion and beliefs and it's part of the curriculum in the*

> *Bachelor of Sciences in Nursing in the Philippines.* (Joseph 7th year NZRN, Filipino)

Joseph clarified his position further when he explained that he felt that his cultural care delivery had not changed when doing the CAP and stated that he felt he was already skilled in this area.

> *Personally, I think cultural safety is within the person. So, for me personally, it didn't change because I respected any culture whatever there is, it's just a matter of knowing the culture. In terms of knowing the Pasifika or the Māori culture, that's something that we have not been educated much in the Philippines because it's not a majority part of our culture. So that's a learning curve for me, but I think once you've learnt it and you know what the culture is all about and you immerse yourself in this new environment, in this culture, I think it's the same. It's respecting the cultures that you don't know and being aware of things that you are not aware of.* (Joseph 7th year NZRN, Filipino)

Minimal New Knowledge Provided of Cultural Safety in Aotearoa Nursing. Equally, a few acknowledged differences in environment, culture, and language as exceptional, and the CAP clinical placement and length were not seen as conducive to gaining cultural insight into the patients and their needs.

> *It was really overwhelming. I think that with a two-week classroom session they could have prepared us more. They were telling us that there will be different nationalities, different cultures and beliefs of patients we'll be looking after. People from the UK, or Māori patients and people from other countries and the sense of humour will be different and it was a struggle for me to recognise.* (Sarah 8th year NZRN, Filipina)

Joseph alluded to why he held his thoughts about the struggle for some CAP students to become familiar with cultural safety aspects of their nursing care provision.

> *CAP is very structured; it is no real life. There's no real-life cultural experience there. In terms of the lectures and introducing culture on a big textbook base, I think that was good, but I think experiencing it in real life is always better. Its six weeks of placement and it really just*

> *depends on who you'll get to interact with for those six weeks so it's not enough to be honest with you. And to be really fair, even if it's a year, if your put in a job placement that you don't experience something, you'll never experience it.* (Joseph 7th year NZRN, Filipino)

Michaela, in contrast, felt that the CAP placement had been enlightening and stated that she found Aotearoa to be more culture sensitive. She discussed how she saw the differences relating to the patients' rights and how this had changed her way of working.

> *In the rest home there are so many vast cultures; there are Indians, Chinese and Kiwis. They're very particular with the rights here in NZ, like the right of the resident is very much carried out, but in the Philippines, we don't. So, we don't usually talk [to the resident] often or it's not tackled. It's not always an issue regarding rights and culture and things like that. For example, if it's the wish of the resident to be cremated, or something like that. In the Philippines, we don't have those EPOA[3] things and then we don't talk about family rights. Like if the family decided ok this [sic] is for mum, it's not the patient's right. It's not going to be discussed.* (Michaela 3rd year NZRN, Filipina)

She further discussed how she had changed her behaviour due to her experience on the CAP and the effect this had on her subsequent acculturation into the nursing culture in Aotearoa.

> *It was a bit hard and you have to be considerate. You have to check yourself all the time. When I did my clinical practicum, I had various ranges of people. There were similar ones and there were different cultures. When they die you have to follow this and follow that, and they don't want to eat this and things like that. It's important to each and every one. And each and every individual is not the same. Chinese and Filipino and Indian residents, and they all talked their own language; and it's very hard because in the Philippines we talk one language which we understand and here we have to speak English all the time. We have to be really good in communication, not only verbally, so that we will be able to carry out our duties to our residents. For me it was a different*

[3] EPOA, Enduring power of attorney – is the legal document in New Zealand which sets out who can take care of your personal or financial matters if you are deemed unable.

> *shift in the kind of job that I have, aside from just giving medications, you also need to consider something else deeper than that. It's more of, like, you have to be considerate with the culture. Always think of the rights of the resident, always think of their safety. They should always be culturally safe, so as long as you keep your residents culturally safe and their wishes being followed, I think that's the best thing that you can do.* (Michaela 3rd year NZRN, Filipina)

Maria gave an example of culturally safe nursing from her CAP placement and illustrated how she would never forget the lesson she had learned from it and how it continued to shape her care provision.

> *We had an elderly patient in the care home, I can't remember his name, but he was saying that he was a Māori, a high up Māori chief. His family members said that he was a chief so that we had to care for him differently. And when we wash patients, we have a basin, like, when we wash the face and when we're doing them in bed and not showering, the face and the body and that, you know how you're washing? He told me that the basin should be different for his head. It shouldn't be even; do you wash the basin. No. It has to be a different basin for the head, and that's respect and all that. Yeah, ok, it's not a problem, you know the patients' rights and all that. But then we had a problem at that time because our clinical manager was not happy with that. She wants us to use the same basin for the head and don't care what he [the resident] says. "What you do to other residents you do to him. I don't believe he's a Māori chief or whatever". But I didn't follow her, I just followed what the patient's wishes are. I said, ok that's your right, respect and I would participate in whatever your family wishes.* (Maria 17th year NZRN, Filipina)

Although many participants recounted how their CAP course had not thoroughly explained the theory of cultural safety, many unconsciously aligned it with the learnings from their te Tiriti O Waitangi sessions. These participants appeared to state that way of working was one that they already did but that it was now named.

> *It took a while to get used to the idea, but you can also see that you kind of do it anyway.* (Aiko 3rd year NZRN, Filipina)

Cultural Safety Versus Te Tiriti O Waitangi; Participants' Perceived Understanding of its Relationship to Nursing Care Provision. Cultural safety and working towards te Tiriti o Waitangi appeared to have become the same concept for the participants and were presented as an indistinct line. Many of the examples given were about their experiences of following the beliefs and wishes of Māori patients specifically. It became apparent that this was the meaning attributed to cultural safety in their CAP placement as their responses regarding their understanding of the differences in cultural care provision in Aotearoa centred around this topic.

> *I can't remember the CAP content exactly but when a patient comes in, we need to know their culture so we can apply the appropriate intervention given to that patient. So, I remember that time when somebody told me that nobody should sit on the table because I think that's a Māori culture. So, make sure that it's not to be seated there.* (Lucy 5th year NZRN, Filipina)

> *It is only a two to three-month course, but I think it's crucial for international nurses because at least they need to know the people. I know NZ is now getting much diverse, multicultural, but we still need to know the roots and all the cultures in NZ.* (Jacob 7th year NZRN, Indian)

Anu gave an example of how she had interacted with a Māori family during the terminal stage of their relative. She found it to be helpful in managing her nursing input and identified how she understood the underpinnings from te Tiriti O Waitangi in relation to health care provision and how this was core to the message of cultural safety for her.

> *I would say that they reinforced it here and give very big importance for cultural safety here. So, we have that written assignment as well so we could think about it. Working with different people definitely helped, I would say. I know there are things that I have to keep in mind when I'm caring for a patient from a Māori culture. We were told that people here need to be involved in the care. They like to make decisions; they like to be told about everything that's happening and then they make the informed decision. And the importance of family, how they also get involved. Preferences about whether they need to get this particular treatment or not, blood transfusion, a lot of things like that. They like to participate and make those decisions and just not talking about them*

> *and doing your own stuff but involving them in everything that you do. So, we had a deteriorating patient and the family like to be informed, they like to be there. They didn't want them to do alone. At least a healthcare member had to be there. I learnt that it's really important. So, after time after that, I make sure the family knows and at least somebody is there. Even if not the family, somebody sits there with the patient.* (Anu 6th year NZRN, Indian female)

Jacob, similarly, spoke of his experience with care provision within the Māori culture and how he had learned about what to offer when dealing with family and the end stages of a patient's life.

> *When it came to family, especially when it was a Māori family and when someone was dying, we know how the whole family, or the whānau come together and how it is quite important for their culture.* (Jacob 10th year NZRN, Indian)

Whilst many participants could talk of how they understood cultural safety, there did not seem to be much depth to their knowledge and interpretations of the concept. A few spoke of their primary working practice in general as examples of their learnings from the CAP and their current knowledge.

> *In my CAP, we have the classes first before we go to the placement, so they sort of gave us an idea how different cultures are. I mean the European Kiwis mainly of course you just have to think how you would want to be treated. Mainly it's just a rule that you treat each other with respect. It's the Māori ones that I was a bit cautious about, not really like cautious but something like that. Because I heard that they have different things that, for example, you can't just touch their face or their head without asking for their permission. And, for example, with a European Kiwi man, they don't mind if you use their table for putting clean things on, sometimes there's a hook there. But then, apparently for the Māoris, they don't like it there because it's just for food and that's different.* (Joy 5th year NZRN, Filipina)

Many participants explained that their CAP te Tiriti O Waitangi component had been short and basic, and that they could not reliably remember any of the content. Some stated that

they had received a half-day on the subject and were only advised to keep Māori culture in mind when caring for their patients. Others suggested that they had learned more after completing the CAP, either by attending Tikanga study days or asking their colleagues for information. However, understanding the importance of working to te Tiriti was at the forefront for the participants. Jacob was able to discuss the specific session he had attended on the Treaty.

> *We got to know a few things like the Māori culture, triple Ps[4] and things so it was good for us that we were aware. I got an idea of what triple P was because we were incorporating it in our day-to-day practice.* (Jacob 10th year NZRN, Indian)

However, the rote learning of the term 'the three Ps' seemed evident as the participants could not give specific examples relating to its meaning. Maria gave slightly more information about the three Ps in her course content but stated that she had not cared for any Māori patients in her clinical placement and had learned most of her knowledge after the course.

> *At that time of the CAP, we were not actually aware or familiar with the Māori culture and all that and the Treaty of Waitangi and the three Ps. But when we had that half day, or three hours we were given the history and how were going to deal with Māoris and what happened in the past and how we can deal with that in our nursing thing. After that I learned a lot when I started working when we had lots of Māori patients.* (Maria 17th year NZRN, Filipina)

In contrast, Joseph gave examples of how he saw te Tiriti o Waitangi in his clinical placement area procedures and how this related to his current work.

> *The Treaty of Waitangi and the bicultural lesson, the Māori, the Pākehā[5] and the different cultures are all relevant because you get to experience it every day in your work life. For example, if they want tissue returned to them, which is really, really big, it's very important to them for cultural reasons. So, we put up a policy for it, so it doesn't get missed, it*

[4] The three Ps of healthcare provision in New Zealand—partnership, participation, and protection—underpin the relationship between the Government and Māori as per Te Tiriti o Waitangi and were used to show how healthcare professionals should work together with Māori to achieve health goals prior to 2019 when the principles were re-written (Ministry of Health New Zealand, 2020).

[5] Pākehā – term to describe a white New Zealander not of Māori descent.

> *gets logged and it gets returned to the patient appropriately. So those are some of the things I was taught, and I see them as really important. Or, for example with a family and it's really important about including the family in the environment that we work in and if they have families coming in with them [to theatre], you include the family in your teaching or interaction with patients. We see just that one patient, but they probably have two, there family members coming with them and we always include them, we make sure they are part of the patient's journey.* (Joseph 7th year NZRN, Filipino)

Similarly, Lucy explained how she used te Tiriti principles in her workplace and related them to her current work using the learnings from the CAP.

> *For example, for participation, we encourage independence in doing dialysis, so we encourage the patients to line the machines. We communicate to them that its beneficial if they participate in their treatment. Then they will do that, participate in the course of care. I remember there was a time that a patient has this necklace and it has a significant meaning to them. And when I accidentally touched it, he said to me that it shouldn't be touched. So, when I knew it was important for the patient, I respect that and the next time I do the care, I see not to touch it.* (Lucy 5th year NZRN, Filipina)

The linking between te Tiriti o Waitangi sessions and the subsequent care provision to patients were mainly described as having been consolidated after completing the CAP course. Different cultural aspects to their initiation into Aotearoa were seen to relate more to their social environments; and their experiences of aspects of the CAP and how these had helped them understand practice as a RN in Aotearoa.

Overall Experience

The novel findings presented here look at other important aspects of the CAP course that influenced participants in their subsequent role as registered nurses in Aotearoa. The information was provided in answer to the question: "Is there anything else you would like to say about the CAP course?". They illustrate the participants' perceptions of how the CAP course elements were considered regarding their IQN registration process. Furthermore,

one participant questioned the equity of applicants for Aotearoa RN registration and compared it to a friend who had a different experience.

Joseph offered his thoughts about the Aotearoa nursing registration process when he talked about his three nursing registrations and how marked the difference was in obtaining them. He further offered his ideas on how he thought the system could be improved to ensure the best results for Aotearoa nursing.

> *So, I am a licensed nurse in the US as well. Their testing system is different. I had to prove my assessment skills and all of that. There was a paper-based question designed for the exam. It was a different approach to NZ. So, I think it's different here but relevant. I think it could be improved [here] because a lot of them [CAP courses] are self-assessment based on the competencies which I believe is really good. But I also believe as an IQN, in order for us to make sure we maintain the standards of our nursing in NZ, there should be testing on nursing knowledge based on how they are able to do their nursing duties.* (Joseph 7th year NZRN, Filipino)

Michaela, too, spoke of now having registration in a third country as she had already obtained visa and registration in the USA. She described how the process had been different, but time-consuming, and how it had added to her wait to obtain Aotearoa nursing registration.

> *No, it's not a similar process. So, I took my IELTS for visa screening and then I took an entrance exam. When I passed, I got my licence straight away. But then I have to wait for a company to sponsor me for an immigrant visa. But it was taking too long, like five years and then it got to a point that I had already got pregnant, had a baby and then we came to NZ. And then my American dream was gone. It was satisfying [to get NZ registration] and I was overwhelmed because this is my third licence. When I got my licence here, after three years the US company called me up and offered the immigrant visa for me and my whole family. But then, it's actually harder to get your NZ registration than your US one so I'm not going to give up on this one.* (Michaela 3rd year NZRN, Filipina)

She further outlined how the difference in obtaining registration in Aotearoa was marked compared to her knowledge of other IQNs in different countries.

> *I think having the CAP course is a good thing but as well they should consider that we also got our license back home already. But, it's probably a matter of maybe because we can't speak English, I don't know. It's kind of hard because if they assess IQNs like Filipinos and Indians in this way, I think they should do it to everybody else. I've got a friend who's a nurse in Singapore and she did not undergo a CAP course, she just took the IELTS and she got her license and it was kind of unfair. It's interesting to know that there are differences and how they gauge the IQNs, but I think if they're going to do it they should be equal, doing it to everyone. Not only to Filipinos and Indians.* (Michaela 3rd year NZRN, Filipina)

Summary

This chapter has summarised the findings of the experiences IQN participants on how they perceived the CAP course components were significant for their subsequent transition into working as RNs in Aotearoa. Regarding their perceptions of the CAP clinical practice component, changes from previous experiences working in acute nursing to moving to unfamiliar aged care clinical areas during the CAP course proved unsettling. This diminished confidence, resulted in humility, and left others feeling deskilled. Reflecting on their understanding of clinical practice procedures during the CAP offered insights into how the participants felt somewhat secure in their abilities and knowledge base, and how this aligned with their understanding of accountability in the role of a RN. This illustrated how their responsibilities after their Aotearoa nursing registration was markedly different from that in their home country experiences due to the CAP highlighting more balanced professional power in Aotearoa than in their previous professional work. Knowledge of cultural safety in nursing was seen as 'business as usual' for many participants who described they already held a clear understanding and interpretation of how they would provide nursing care for their patients. Reflection on their previous experience with cultural diversity in their home country served to promote their confidence in enacting their new nursing roles. An indistinct line between cultural safety and the knowledge and application of te Tiriti o Waitangi was identified and will be explored in the next chapter.

The most important aspect of the participants' experience of the CAP overall was the acknowledgment of the difference in power balance amongst the healthcare professionals they interacted with combined with the significance of the clinical preceptor support with nursing knowledge and communication during the clinical practice component. The professional support obtained from the preceptor and tutor network appeared to have positively influenced the participants integration into the Aotearoa nursing workforce whilst on the CAP and subsequently in their current RN roles. This information will be presented and critiqued against international and local literature by relating the above findings to the original research question.

Chapter 8 Discussion

This chapter contextualises my research findings with the international and regional literature on the acculturation of IQNs into a host country's nursing workforce. The research examined specifically whether previous CAPs had enabled a successful transition to Aotearoa clinical and cultural nursing practice for IQNs who had undertaken them. In addition, this research explored key research questions about IQNs' perspectives on elements of the CAP that influenced their transition to the nursing workforce in Aotearoa. This chapter will focus on the key findings from the data obtained from the IQNs, and critique these against the local and global contextual and contemporary research literature. This discussion is organised around addressing the research questions drawing on the main themes from Chapter 7 as well as the those of acculturation as outlined in Chapter four.

In addition, the discussion includes further comparisons and contrasts between the two ethnic groups of IQNs from the Philippines and India's experiences as presented. Finally, novel information arising from the study on preceptor support and CAP financial considerations is presented and further critiqued.

First, in response to the research question on participants' perceptions of satisfactory or unsatisfactory components from the CAP experience and the overarching emerging theme throughout the data, I will frame social dissonance arising from the participants' confusion with their communication experiences, particularly local colloquialisms and accents encountered in the CAP course. Then, I will discuss how this was seen to have affected their transition through the acculturation cycle and, ultimately, affected their ongoing professional communication and patient management.

Second, I will address the research questions of differences in nursing practice encountered by the participants during the CAP and what specific clinical accountability and responsibility elements were seen as applicable to their current RN practice. Furthermore, I will critique the professional dissonance encountered, focusing on participants' unfamiliarity with the specific needs of older patients in residential aged care and the appropriate nursing clinical practice required during their CAP clinical placement. Additionally, I will discuss how this led to the participants' thoughts of feeling deskilled due to perceptions of completing non-complex tasks in their clinical placement. Finally, I will discuss how participants' unfamiliarity with the RN role in Aotearoa confused their prior understanding of the nurse/doctor hierarchy in various healthcare settings.

Next, I will address the research question regarding the perceptions of whether the concept of cultural safety in nursing differed from participant's previous clinical experiences, and whether this related to their subsequent understanding of te Tiriti O Waitangi and its implementation in healthcare in Aotearoa. Additionally, I will identify possible reasons for participants' misunderstanding and amalgamation of the concepts in conjunction with the international literature.

Finally, I will consider the participants' overall views of feeling devalued and deskilled in the Aotearoa healthcare setting and humbled by the process of having to undergo the CAP course to obtain registration as an RN. Following, is a section on novel information obtained on participants' overall consideration of the CAP course and its relevance to becoming a RN in Aotearoa.

Social Dissonance

Confusion, or dissonance, around meeting new and unfamiliar social settings is identified as one of the components of culture shock (D'Souza et al., 2016; Winkelman, 1994) (see Chapter 4). The following section builds on the overarching information from the data in response to perceived satisfactory and unsatisfactory components of the CAP and highlights the most common confusion encountered by the participant IQNs in their transition to working as RNs in Aotearoa—communication barriers, specifically confusion around accents and pronunciation.

Communication Barriers

As outlined in Chapter 6, all participants were at least two years post-nursing registration in Aotearoa at the time of the interviews. In addition, all participants had completed the initial requirements for accessing a CAP, as outlined in Chapter 2. Nevertheless, some participants described barriers to communication whilst on the CAP. Communication has been shown to be a vital element in acculturation into a host country (Hui et al., 2015). Accordingly, the research findings noted communication as having been an issue during the CAP course for the participants as it emerged through their responses to all questions. Therefore, identification of how communication and possible confusion are relevant to the research findings is discussed and interwoven through the themes and sub-themes in this chapter, beginning with how the participants reacted to the new accent and pronunciation of words they encountered.

Confusion Around Accents and Pronunciation

As described in the previous chapter, the main issue of confusion socially was participants' difficulty with communication during the CAP. The Aotearoa, or 'Kiwi', accent and local colloquialisms were the primary source of confusion and embarrassment for some participants and appeared to add to their stated difficulties of social interactions at work. The adjustment to hearing and interpreting a different accent to provide nursing service relied on participants' ability and confidence to ask people to repeat what they had said to them; for example, a Filipina participant described their initial challenging interactions with patients in the findings section due to a misunderstanding of local pronunciation of vowel sounds, such as the head ("hid") of the hospital bed ("bead") meaning the IQN was unable to complete the request for their patient. Another participant stated they had just begun to understand the accent when they had to move to a different clinical area, where they started the learning process again. The participants' reports of these findings suggest that their communication and English language use improved after completing the CAP course and became more manageable in their social and professional integration period experienced after completing the course, rather than when undertaking it. To illustrate, it was apparent from the communication during the interviews that the participants understood the difference in their current communication skills and were able to compare it to their initial confusion with the language in the clinical settings.

Research has shown that IQNs' acculturation significantly benefits from communicating, forming relationships, and integrating into social communities (Goh & Lopez, 2016). An example is the ability to communicate with patients and their families needing reassurance or explanations of treatments (Zanjani et al., 2018). Further explanations of why nurses must learn to communicate well are improved language competency in social interactions, understanding of humour, beneficial non-verbal communications, and the capacity to change from professional communication to more social use of language when appropriate (Valdez et al., 2021). Consistent with the literature, this research found that many participants initially had difficulty understanding the patients' and staff' accents and colloquialisms whilst undertaking the CAP course during their beginnings of integration into the Aotearoa nursing workforce. Additionally, participants found that learning the local slang and nuances of patients' non-verbal communication were crucial for building valuable social and professional interactions in cultural and professional contexts (Brunton & Cook, 2018). Therefore, it follows those patients who had perceived the participants as friendly and knowledgeable were more likely to approach or interact with them. Conversely, poor

communication, such as the lack of social interaction due to lack of confidence in their communication ability, and the reported embarrassment of continually asking for help with language, may have affected health care provision and overall poor patient outcomes (Choi et al., 2019). In line with the international literature presented in Chapter 5, this research found that the participants' reports of their social interactions with patients after completing the CAP helped them form therapeutic relationships and integrate into the local community with more success (Brunton & Cook, 2018).

Professional Communication issues

Findings from the research provided insights into the communication barriers encountered by the participants in their CAP regarding the Aotearoa accent and the different technical words and pronunciations. Exposure to the professional language difference was reported as challenging for some, although participants stated it had become easier to manage over time.

The research findings also showed that encountering different terminology and local nursing jargon in the clinical placement area was a source of confusion and frustration for many of the participants. As presented in Chapter 7, there were reports of difficulty delegating and allocating tasks to the caregivers in the clinical area being an issue for one female Indian participant. The participant directly related their communication challenges to not having the confidence to deal with the host staff due to their lack of English language proficiency. In this instance, the participant's heightened language challenges may have occurred due to their previous social and nursing cultural experiences. As discussed in Chapter 3, the social and professional development of nursing in the Philippines and India has developed a defined hierarchy in the workforce (Gill, 2018; Liou et al., 2013). Therefore, the lack of respect given to the IQN participants as the RN, albeit under supervision, would have been confusing and may have accentuated feelings of devaluation.

A factor commonly identified by recent research and this study is that barriers to integration into the host country and workforce can occur for IQNs through lack of adequate communication (Chok et al., 2018; Gillin & Smith, 2021; Nortvedt et al., 2020). In addition, the participants' reports of low self-esteem and confidence in their work roles may have limited their professional standing as seen by the staff in their clinical placement (Valdez et al., 2021). For example, reports of negative feelings and the noted visual demeanour of the participants during their interview occurred at times when the discussion centred around communication issues and of feelings deskilled and devalued.

Further instances of feeling devalued in their role as experienced nurses are notable by Filipino participants' self-voiced description of being 'students' whilst on the CAP instead of acknowledging they were RNs working under supervision. In addition, the participants' responses relayed further cultural discomfort of addressing the doctor, their tutor, and clinical instructor by their first name during their placement. However, notable differences in the Filipino and Indian nurses' use of communications and hierarchy were offered to explain this discomfort by a Filipino participant who described the Indian nurses as being more subservient and less able to become autonomous in their interactions with staff. Montayre (2016) alluded to this identification of Filipino nurses as globalised professionals with the ability to integrate into the host country's workforce with ease due to the use of the American English language in nursing education in the Philippines. Further support of this theory occurred in the interview data when a male Filipino participant did not consider introducing new words and colloquialisms a big problem. Instead, he recounted learning the new names for equipment and terminologies as being simple to do and that it was not significant for him. Participants also used the example of communicating in English with textbooks and classroom use during their original nursing education in the Philippines. However, this participant undertook his clinical placement for the CAP in a more task-focused area of operation theatres, where his prior nursing experience lay. Therefore, one can assume that he would have been comfortable with familiar work systems and processes. Furthermore, from his interview and demeanour, it was apparent that he had not experienced more intensive change to his nursing practice as other participants experienced during the clinical practice element of the CAP. As discussed in Chapter 3, there is minimal nursing overview in aged care settings in the Philippines, and the other participants would not have had the working experience of being in an aged care facility during their initial nursing education (Brodit & Noroña, 2021).

Furthermore, again discussed in Chapter three, the Filipino and Indian nursing education systems vary from the Aotearoa nursing education framework (Gill, 2018; Masselink & Lee, 2010; NCNZ, 2021c). Although the language used in the classroom settings in nursing education in all three countries—Philippines, India, Aotearoa—is English, there is a marked difference in the hierarchy and communication systems expected. This difference in communication styles led to challenges and confusion for the participant IQNs during their first exposure to the Aotearoa nursing workforce on the CAP clinical placement.

There is a need to ensure successful communication in the clinical nursing area and service provision for patient safety and optimal health outcomes. Chapter 6 presents the reasoning

for the choice for the decision that all participants were chosen from two specific ethnic groups in this study, previously identified as the largest IQN populations in Aotearoa (NCNZ, 2020). English was noted to be a subsequent language for all the interview participants, identified as IQNs from the Philippines and India. Due to English language complexities between native language and subsequent language use, this research and international studies have identified communication as a significant issue for the participants and for IQNs generally in a host country (Liou et al., 2013; Philip et al., 2019). For example, despite global English language examination testing requirements to obtain nursing registration, as outlined in Chapter 2, the participant IQNs described struggles with social and professional communication during their CAP course (Nourpanah, 2019; Valdez et al., 2021). Similar study findings in Aotearoa identify lack of communication as troublesome professionally; and, in some cases, causing compromised patient care provision (Bland et al., 2011; Brunton et al., 2020; Montayre et al., 2018). However, the English requirements for registering IQNs in Aotearoa are similar to other developed countries. Additionally, they are mandated in the process prior to application to register (NCNZ, 2015a). In conclusion, effective communication is essential in nursing to ensure safe and positive patient outcomes, and testing its use professionally should balance the need for professional and social contexts to prepare nurses to proficiently interact with patients (Carr, 2021).

English language testing requirements are set at specific pass requirement levels for two different vocationally and academically based tests used by host countries in IQN assessment processes. Before developing the OET, the IELTS was used for migrant health professionals to register in host countries. However, currently, the OET is preferred by nursing and medical communities globally due to the primary focus of the test being the use and understanding of healthcare professional language requirements (Carr, 2021). All participants in this research had previously met one or other of these testing requirements; yet, during the interviews, they described difficulties with conversations with both patients and staff. Although this may have been due to comprehension issues owing to different accents, learning local slang and professional jargon, it is worth considering that the participants were already stressed while undertaking the CAP course. Therefore, the stress of passing the course would have significantly added to difficulties in learning new and different practices. In support of this understanding, the participants voiced their gradual growth in confidence and adjustment to nursing roles *after* undertaking the CAP.

Similarly, a male Filipino participant suggested that the IELTS test had not prepared him for working as a nurse. He stated he found the experience of talking to patients from different

countries outside of Aotearoa to be problematic in considering their cultural safety and health safety. The participant also stated that some staff would find it easier to talk to each other in their native primary language at work; however, he acknowledged this had the effect of confusing the participant and the patients as he had not understood the language spoken. The research findings support the need for English testing as it is necessary for the IQNs to communicate safely with patients but does not support a specific test for use. Chapter 2 outlines that both IELTS and OET test results are accepted for Aotearoa IQN registration applications (NCNZ, 2015a). However, there is a suggestion from the research findings that the OET as a professional language test would be preferable for supporting the growth of patient and nursing interactions from a safety and confidence perspective.

After completing the CAP, the transition to a new language and professional terminology was evident in participant responses to the interview questions. The thread that ran through their replies was the combination of learning new skills and concepts whilst adjusting to the new work environment and the need to provide a culturally safe nursing service. To illustrate this point is the example of one Indian participant who spoke of using critical thinking and practical reasoning during the CAP. They stated they had taken a master's degree in an Aotearoa university after completing the CAP course and had learned these terms there. Nonetheless, many participants reported a delay in understanding local communication in the community and the workplace concurrent with their CAP course attendance. Some attributed this to the brevity of the CAP course and the subsequent need to move to find work. However, several participants had been in Aotearoa for many years, and this would have accounted for their skill in communication in the research interview. Conversely, a few participants, who had completed the CAP course more recently, still reported issues with becoming used to the healthcare system.

An explanation for the delay in acculturation to the nursing workforce is the participants' reported length of time subsequently worked as a RN in Aotearoa, as noted in the demographics (Chapter 7, p. 76). However, in the literature, there is no specified time for migrant nurse acculturation (Aggar et al., 2020). In addition, it is acknowledged to be a cyclical process that may be ongoing and not resolved for some (Choi et al., 2019). Accordingly, the research participants' workforce acculturation delay could be attributed to the fact that many participants reported that they undertook their placement on the CAP course in unfamiliar clinical areas.

Professional Dissonance

This section provides information regarding the participant's experiences from their CAP, about what differences, if any, were encountered between the clinical component of the CAP and previous clinical nursing experiences. It illustrates the participants' confusion about working in an unfamiliar clinical area, their reports of encountering different nursing practice and their perceived inability to utilise their prior knowledge and skills during the CAP. Additionally, information is presented on what clinical accountability and responsibility elements from the CAP were seen as applicable to their current practice as RNs. Responses to these and a further question on what other components were seen as satisfactory and unsatisfactory from the CAP forms the following exploration of the clinical practice component of the CAP curricula.

Clinical Practice Component

This research provided evidence that many participants were disappointed with the allocation to the clinical practice areas assigned to them for the CAP course. The participants evidenced this disappointment in their statements and body language during the interview process, as described briefly in Chapter 7. In addition, evidence was provided of lack of choice over the area they were placed in, unfamiliarity with the terminology used, combined with a lack of knowledge of the specific needs of their allocated patient population. According to many of this study's participants, aged care facilities was the only available area for clinical placement. This situation resulted in voiced frustrations of not working in a hospital with more acute patients and statements that they felt they were not learning anything new in the aged care settings. They further stated they felt uncomfortable and limited in what tasks and skills they could use in their placement. The lack of options for placement may account for the sense of dissatisfaction and discomfort apparent in responses around the devaluing of their skills and qualifications by co-workers whilst on placement.

CAP course providers typically organise the clinical placements required for IQNs' course completion and are limited to facilities that agree to accept students. In addition, these facilities must have systems to provide support and teaching opportunities for the CAP students on placement with them (NCNZ, 2008). However, CAP providers continue to face challenges in availing of acute care placements for their students. This is largely due to the reluctance of acute care providers, such as DHB hospitals, that have formed a view that the IQNs lack professional competence and require more support from staff preceptors (Bland

et al., 2011; Bland & Woolbridge, 2011). Although previously recognised as being skilled and educated in their own country, research participants reported that they felt humbled and frustrated by having their experience and knowledge examined by their work colleagues and preceptors on the course.

This research finding supports a contention seen in the literature (Nourpanah, 2019), that workforce discrimination concerning the IQNs' level of nursing knowledge and skill base can lead to cultural dissonance, feelings of confusion, and conflict in people changing their cultural environment (Choi et al., 2019). Steviano et al. (2017) agreed that support from the host country is pivotal for enhancing migrant nurse integration into the workforce. However, although it has occurred in other countries, it has not affected the participants in this study to the extent that they chose to return to their home country, as many others have been shown to have done (Nourpanah, 2019). The participants stated this was predominantly due to all their hard work towards completing the complex process to obtain registration in Aotearoa. In addition, they reported having mixed feelings of being held back in terms of being allowed to practice skills; yet of having the overall support from preceptors whilst on the CAP course.

Participant reports of working primarily with non-professional colleagues in the aged care clinical area, such as healthcare assistants, dismayed some who intimated that they felt undervalued compared to their CAP course peers in acute clinical placement settings. In addition, further exploration of the participants' experiences about the clinical practice component of the CAP highlighted and mirrored this and several other issues from the literature: technical differences in the workplace, culture shock related to new workplace expectations, and experiencing differences in cultural values (Choi et al., 2019; Roth et al., 2021; Shafaei et al., 2016; Woodbridge & Bland, 2010).

Concerning technical differences in the workplace, the participants' reports of unfamiliarity with working with older adults in an aged care facility are linked to their expressed expectations of learning new and exciting techniques and processes. Their commonly articulated view of clinical time as being 'basic' or non-complex is one such illustration. In addition, unfamiliarity in the processes, assessments, and medications required in the aged care service may have engendered lack of acknowledgement of the clinical practice requirements (Viken et al., 2018). Furthermore, the research findings suggest both ethnicities, Filipino and Indian, encountered confusion around the awareness of the complex skills needed for their older adult patients in this nursing area (Chok et al., 2018).

The literature widely acknowledges that gerontology patients have a complexity of needs that will require specialised assessment and care planning (King et al., 2018; Sasser & Moody, 2018; Tanyi & Pelser, 2019; Wen et al., 2019). Therefore, the participants' experiences working within this clinical speciality with only older adults will have been required to focus their underpinning theoretical nursing knowledge and skill base on unfamiliar conditions and medications. Finally, as the CAP course timeframe is short and reportedly limited to placements in aged care, the participants' experiences will have been stressful for them regarding critical thinking and clinical decision making.

Participants also reported that, in some instances, the preceptor in the clinical placement did not allow them to make decisions. Nor were they allowed to carry out what they considered non-complex tasks that they were familiar with doing in their home country, such as IV medications administration, in the aged care placement. Finally, disappointment in not having what they defined as more acute and typical nursing tasks and roles to complete would have notably coloured their experience and produced negative or ambivalent associations about the placement area and feeling deskilled (Nourpanah, 2019).

Feeling Deskilled

The research findings highlighted the feelings of being deskilled and devalued during the CAP as participants reported the clinical practice experience to be similar to their previous practice in their home country. Furthermore, their inability to undertake what they deemed to be 'basic nursing tasks' and of having to go 'back to basics' was a source of frustration for some participants. In addition, participants reported that they did not feel they had learned new information on the CAP, which was disappointing for them.

Some participants commented on having short classroom nursing education sessions and stated that their anticipated education and link to innovative nursing practice was non-existent in their CAP courses. In addition, their expectations of learning new and updated clinical knowledge were also dashed relatively early in their aged care placements. Participant responses centred around basic and mundane nursing tasks as the most recalled significant experiences. The underlying assumption from this information is that there was little difference in the Aotearoa nursing practices to their home country experiences. Interestingly, the CAP placement in aged care was deemed by one Filipino participant to focus on specialist training in that specific area only.

Nevertheless, the participants did not acknowledge that it required complex nursing skills and evidence-based practice to work with older adults in aged care facilities (Chok et al.,

2018). The disappointment in the lack of new information and education was evident for many Filipino participants and evidenced by despondency in their interview discussions. International literature shows that many nurses expect to learn new and technologically advanced practices when migrating to another country (Viken et al., 2018). This expectation would seem to be the case for the participants in this study too. Additionally, the lack of choice in where to undertake the placement area may have engendered dissatisfaction in some as they may have had a destination job in mind in an acute hospital setting following completion of the CAP course.

The language used in the participants' responses to identify the feelings of being devalued and deskilled corresponds with their experience of culture shock as part of the acculturation process (discussed in Chapter 4) to the new professional environment (Valdez et al., 2021). For example, examining participants' comments about self-effacement and feeling humbled due to not having accurate and expected knowledge of modern technology and equipment further illustrates the participants' lowered self-esteem experiences. One example is the evidence about introducing equipment and processes unfamiliar to one Filipino participant, which engendered humiliation. These feelings were centred around their view of prior learned nursing practices in her home country training as being considered backwards compared to the practices encountered on the CAP course. However, in contrast, one Indian participant's language around the differences in the skills and tasks required on the CAP were voiced more pragmatically. Furthermore, their communication about feeling deskilled centred around modifying their prior knowledge and cultural understanding of how the nursing processes occurred in the new workplace. Finally, their initial frustrations at not learning new clinical information from the CAP course appeared to be linked to the inability to undertake what they considered 'basic' tasks in the clinical area and, therefore, feeling diminished in their role performance.

International studies into nursing acculturation into a host country support these research findings of participants' low self-esteem as a product of their initial integration into the Aotearoa nursing workforce (Chok et al., 2018; Valdez et al., 2021). Furthermore, deskilling, and devaluing IQNs' previous nursing experience in Aotearoa is noted in studies by Walker and Clendon (2012) and Bland et al. (2011). This research found a perceived lack of trust from the preceptors in the clinical area made apparent the need for participants' decisions to be sanctioned by them. Another implication, however, is the notion that the participants were not focused on patient-centred care in their clinical placement but were

more focused on task completion. The importance given to the identification of specific clinical tasks in the research interviews would support this hypothesis.

Similarly, there are reports regarding ethnocentrism in host nations' nursing workforce in both the international and Aotearoa literature (Choi et al., 2019; Nortvedt et al., 2020; Valdez et al., 2021) detailing stereotyping and distrust of perceived 'foreign' nursing practice by nurses from the Philippines and India (Gill, 2018; Montayre et al., 2018). Brunton et al. (2019) posited ethnocentrism as a possible communication issue for IQNs, thus giving credence to the perceived lack of responsibility-sharing for complex task completion during the CAP course. Such connections likely existed between the preceptors and the participants during their CAP course. Possible stereotyping of the participants from perceived 'less developed' countries, such as the Philippines and India, (a context offered in Chapter 3), could also explain the limitations they experienced during their CAP clinical placement. Furthermore, it is suggested that this perception and limitation of using their prior knowledge and skill base will have negatively impacted on their initial transition into and understanding of the roles of RNs in Aotearoa.

Further examination of the research findings provides a difference in how the IQNs from the Philippines and India perceived the significance of the nursing practice encountered during the CAP course for their transition to working as RNs in Aotearoa. As described previously in Chapter 3, the two countries have different social and nursing cultures from Aotearoa (Gill, 2018; Montayre et al., 2018). This inherent professional cultural influence impacted how the nurses understood and adapted to the course's newly presented work and professional roles. For example, the nurses from the Philippines evidenced more dissatisfaction in the lack of acknowledgement of the course presenters and clinical preceptors in their previous education and skills in nursing, often leading to feelings of low self-esteem and discouragement. These feelings correspond with the self-concept of a Filipino nurse as malleable and able to confidently approach any new professional area with ease as projected by their home country values and education expectations (Montayre et al., 2018).

The Indian nurses, however, presented with feelings more akin to disappointment in the lack of provision from the CAP course for learning new or better clinical skills in their allocated clinical practice area. The findings revealed reports of introduction to new equipment; however, participants thought that the course had merely reviewed their already familiar clinical skills. Furthermore, participants in the study offered their opinions

that the clinical component of the course consisted of simple supervised essential nursing task completion with minimal input into more complex nursing roles. In addition, the allocation to an unfamiliar clinical area of nursing for either cultural group interviewed appeared to compound these feelings of disappointment in the CAP course content. Finally, it highlighted the participants' difficulty adjusting to a new country, new nursing role, and new clinical expectations concerning the accountability and responsibility of the NZRN role. Given this information, it is concerning that the allocation of the CAP course clinical practice area occurred without acknowledging the participant's area of experience and knowledge and impacted their perceptions of the clinical practice component of the CAP course.

Therefore, the research findings suggest that assessing the competency and safety of the participants under the restriction of time and role limitations, whilst under supervision on the CAP course was not valuable or relevant to their skill and knowledge base. Due to the brevity and unfamiliarity of the clinical settings experienced by the participants on their CAP, and the complexity of the patient population within it, it is suggested that the clinical placement assessment could have been better served using a generalised OSCE exam (Gillin & Smith, 2021). Provision of a scenario-based exam such as an OSCE for IQNs would better assess general nursing knowledge and assessment skills. Equally, communication ability can be assessed within the OSCE scenario where the language would be pertinent to the clinical situation examined. In addition, although both acute and aged care areas require essential nursing assessment and planning skills, there are specific differences to consider, such as the many co-morbidities and polypharmacy of the aged care patients requiring their stay in a 24-hour facility. International research suggests that acculturating into a new clinical area may take more time for some than others (Goh & Lopez, 2016); therefore, it is unreasonable to expect that the participants were conversant with the specialism of gerontology in such a short time. Furthermore, it can be questioned whether it produced a consistent, valid, and reliable assessment of the participants' nursing skills and safety as required by the NCNZ (2015a). Finally, with respect to the research question about the clinical practice assessment on the CAP course, it would appear that the participants did not find it to be significant for their subsequent work in the RN role.

Another example of disappointment in the CAP process reported by the participants was the strict adherence to guided workbooks for the CAP clinical completion and the related processes linked to meeting the Nursing Council requirements for registration in Aotearoa. These responses support the premise stated by a Filipino participant that the CAP course is not real life, in respect of nursing in general, and is based purely on meeting the NCNZ

(2008) competencies. This sentiment suggests minimal to no nursing knowledge theories were presented and discussed in the classroom curriculum regarding the prospective patient population of older adults in aged care. Furthermore, it would suggest that the nursing practice skills being assessed for competency on the CAP were provided with reliance on the preceptors' understanding and experience with meeting competencies and the current health needs of the aged care residents in the placement. In addition, while the CAP course content focuses on the requirements from the NCNZ, it does not specify the nursing knowledge content required. Furthermore, although each education provider must audit their CAP course content and provision internally and externally (NCNZ, 2008), the content and examination methods of the skills and knowledge of each IQN attending occur according to their interpretation of requirements. The participant responses in this study suggest that their preceptor also appeared to assess each participant according to their interpretations of how they met the competency requirements to pass. As there were no reports of a consistent method of examination, it is contested that nursing theory knowledge of the participants was not tested during the CAP course whilst they were on clinical placement. This is supported by the participant reports of the preceptors being very knowledgeable and the inclusion of the unfamiliarity with the new equipment and practices of workbook completion as being most significant while on clinical placement.

Further examples of the gap in theory and practice during the CAP course are participants' difficulties, stated explicitly in interviews, with unfamiliarity in the use of evidence-based practice in nursing care provision. It can, therefore, be assumed that the use of research and evidence-based practice was an uncommon theme in nursing education in the participants' home countries at the time of their education. Supporting this assumption is the international literature that demonstrates that research and evidence-based practice are not common topics taught in Indian nursing education facilities (Skaria et al., 2019; Vijayalakshmi et al., 2014). Furthermore, a comparison of the findings of this study with others in the international literature (Zanjani et al., 2018) supports the assumption that there is a similar issue with both Filipino and Indian nursing programmes. Moreover, one Filipino participant voiced her feelings of embarrassment at being told, 'oh, we don't do it that way anymore'. This reported lack of awareness of current evidence-based clinical practice, compared to her previous RN roles in her home country, made her feel like she had nursed in a 'backward' manner. Her statement implies that she did not encounter, or was not aware of, the use of evidence-based practice theory content during her CAP course.

This study would indicate that participants' embarrassment at not knowing the accepted and almost routine tasks and equipment in the practice area did not support a positive learning environment. Moreover, participants may have replicated the hierarchical nursing system experienced in their home country, thereby not supporting them to adequately acculturate into the nursing workforce during the CAP course. Supporting this theory, Norvedt et al. (2020) described how feeling belittled in the workplace lengthened the transition to the new workforce for Filipino nurses in Norway. Interestingly, discussions of racism and bullying towards the IQNs in their transition process also arose from their findings. Surprisingly, there were no mentions of racism experienced by the participants during the CAP. Instead, they were pleased to have had a positive, albeit bland, experience. Therefore, this study was unable to demonstrate any issues in this area.

However, the lack of evidence presented by the participants on racial slurs or bullying experiences during their undertaking of the CAP course could also be a result of the socio-cultural backgrounds of their original home and family structures. For example, as shown in Chapter 2, nursing developed as a profession in the Philippines in what is defined as a collective social environment (Broomhall & Phillips, 2020). Similarly, Indian social culture is also collectivist and has an identified structured hierarchy in the nursing profession (Jayapal & Arulappan, 2020). Therefore, due to the inherent cultural values of working together for a shared goal, the participants may have been considered in their responses to the interview questions in light of fellow IQNs applying to future CAP courses. Equally, the researcher's position as the senior person in the interview process may have prevented the participants from giving information about the experiences in a negative light.

Another essential requirement of passing the CAP programme is the endorsement by their preceptors and clinical assessors of the participants' work practices as being safe and competent in clinical nursing (NCNZ, 2008). This confirmation of their ability to understand and meet the NCNZ's professional competencies relies on the production of exemplars from practice that illustrates the nurse's knowledge and understanding (NCNZ, 2007). Observation of the event or discussion with preceptors or tutors on the CAP course provide the indicative content for meeting each competency. While there are guidelines for completing the competencies (NCNZ, 2008), as previously noted, these have not changed in over 14 years.

Additionally, and importantly, CAP IQNs' exemplars are reviewed subjectively by the assessors for each student. The process, therefore, relies on the experience and expertise

of the assessor. The requirement for becoming an assessor is the completion of a preceptor programme and having at least two years of working experience as a RN (NCNZ, 2008). These requirements would suggest that the preceptor may not have extensive experience assessing IQNs. This lack of experience could limit the awareness of appropriate content required for the evidential writing for competencies, resulting in a national lack of consistency in the assessment process. Audits of the written work occur internally, externally in education providers processes, and by the professional body of the NCNZ. However, these audits occur in hindsight. Although the evidential competency requirements may have been met, the auditor still views the content subjectively, thereby continuing the lack of consistency between CAP course providers.

Assessment of the clinical skills required for each nursing area was reported to differ depending on the complexity and speciality of each ward or practice area. Another sub-theme arising from this study is the participants' reported lack of national consistency from the CAP course providers regarding the course length delivered from their educational institution. Successful completion of the clinical placement has no set timeframe or hourly requirement. The CAP course has a provision for six weeks for clinical practice, which can be shortened or extended depending on the decision of the preceptor or clinical tutor (NCNZ, 2008). Reasons for extension must be communicated to the nursing council; however, the final decision is made subjectively, based on the CAP provider's judgment. CAP candidates pass the course when the assessor has deemed the competencies have met their personal and professional standards. Exemplars are, therefore, subjective; and again, their validity is questionable as there is room for ambiguity of interpretation of the evidence necessary to frame each example. Finally, clear direction in meeting the indicated evidential response factor in whether the IQN is truly professionally aware of the Aotearoa nursing culture from their minimal practical experience is not available.

It is acknowledged that nursing is a generic role adaptable to many different specialities (NCNZ, 2021c), and the NZNC's (2007) provision of generic competencies for nurses in all clinical areas supports this view. However, the noted lack of consistency in programme content and placement area between CAP course providers (Bland et al., 2011) raises questions around the validity of the assessment of safety and competency in general nursing for national registration. In addition, the lack of a consistent model for completion of the competency assessment form can lead to confusion around the interpretation of how each competency is or is not met.

Another aspect of the ambiguity of the CAP course assessment for the participants relates to reports of differences in time each person spent on placement. These issues may have contributed to the problematic experiences of participants, with several citing how short the course was and how it did not offer them a real-life aspect to nursing. Acculturation to workplaces takes time (Berry, 2005; Shafaei et al., 2016). With the short 4-6-week clinical placement on the CAP, it is not surprising that the participants described feeling uncomfortable and did not recall many positive influences from their clinical practice. Lack of specific time requirements lends credence to the suggestion of subjectivity of the current CAP and may account for some of the discomfort reported in the interview data of the research participants.

Unfamiliarity with the clinical requirements for meeting the CAP course standards of a pass was notable in the participants' responses to questions around assessment skills and accountability for decision making for their patients' needs. In addition, the participants' interpretation of being underutilised during the CAP course clinical component were a clear indicator that they did not recognise the content and context of the aged care placements as having great importance for their assessment for competency.

The findings of this research are consistent with international research into perceived discomfort in nursing and, in part, due to the difference in value-based beliefs regarding elderly care and the nursing practice that this requires (Choi et al., 2019). One explanation stems from the information given by the Indian participants that traditionally the family are primary providers of care for the elderly in their home countries. Corroboration for this statement is that residential aged care nursing did not commonly exist with a full nursing staff overview in India until 2008 (Johnson et al., 2018; Menezes & Thomas, 2018; Stievano et al., 2017). The study participants defined palliative care concepts and the prevention of hospital admission in aged care facilities as new and uncomfortable. Shetty (2012) recognised and discussed these feelings in their study participants, noting that many developing countries do not have aged care systems. Therefore, countries like India will have a different concept and scope from Aotearoa. Similarly, Dubey et al. (2011) discussed the unpreparedness of nurses from India to change cultural views on elderly care (where it is familial not institutional see Chapter three) in the light of growing numbers of the older population with unique health needs and no close family to look after them.

The Filipino participants also described a culture of family-centred care in their home country. Like India, aged care facilities are not typical in the Philippines (Brodit & Noroña,

2021; Cassie, 2017). The Filipino participants explained that elderly parents live with their extended younger family members. This detail was notable in parts of the participants' discussions indicating the significant difference in their CAP course experience to nursing in their home country. The research findings of the participants' discomfort in adapting from acute nursing practice to aged care also support the Aotearoa study carried out by Jenkins and Huntington (2016). They presented IQNs' unfamiliarity with the associated complexity of medical conditions in aged care and the exposure of their assumptions around nursing care practice for the residents. The recounted lack of confidence and identification of being students during the CAP course suggest that the clinical practice setting, and timings are not a valuable mode of assessment when assessing their competency as RNs.

The need for these IQNs to adjust to different nursing practices was not seen to have been given enough time and importance in their CAP courses. Adaptation to differing clinical practice for specific clinical areas with expected skill sets and tasks within each specialism is common in nursing (Zambas et al., 2016). However, the research findings suggest that the participants felt that their skill set was neither recognised nor utilised well in the aged care setting. Given that the initial and recurring processes of IQN recruitment to Aotearoa nursing have as their focus a target of filling nursing roles in aged care facilities (NCNZ, 2013), this is more than slightly concerning. Also worth considering is the validity of assessing nursing competency during the clinical component of the CAP if the IQNs are neither familiar with the gerontological issues encountered nor the associated specialised nursing assessments and care planning (Walter, 2017). Coupled with the brevity of the clinical placement period, this issue supports the idea that the clinical practice component may not contribute to a fair assessment of IQNs' skill set and ability to show critical thinking. Brunton and Cook's (2018) findings from their study into workplace communication between RNs also support this theory. Their statement that providing more time for communication will allow efficiency and safety in the workplace echo that of my study participants' responses around their growth in communication skills following the CAP course.

Many participants stated that they felt that they had evolved their skills and knowledge base after completing the CAP course. Additionally, they did not feel that the clinical period in the CAP course had contributed more than a brief introduction to the nursing profession in Aotearoa. However, as the CAP course is primarily competency-based, a question arises around the justice of assessing nurses on standards for nursing that they are not familiar with within such a short time frame. The findings of the current study suggest that the

short CAP course does not allow for more than a brief time to accurately assess competency and safety in a nursing area unfamiliar to the IQNs. Therefore, as competency in nursing is supported with clinical responsibility, accountability, and assessment-based decisions for service input, it exposes a need to consider a different model of introduction and transition to general nursing in Aotearoa.

Hierarchical Differences

The research participants' understanding and interpretations of accountability and responsibility, as demonstrated in their nursing roles on the CAP course, must also be considered in respect of the assessment of their competency. In order to obtain insight into their understanding, the interview questions asked how the participants felt the CAP course had provided an understanding of how RNs in Aotearoa worked and managed health care planning for patients. The self-labelling of the participants as being 'students' and their reports of not being the decision-makers in the clinical placement provides an insight into where they felt their hierarchical place on the course sat in regard to transitioning to the role of RNs themselves.

Interpretation of their comments and visible attitudes during the interviews suggest surprise and awe of the new visualised relationship between the RN and doctors in the clinical area. For example, during the interview, one Indian participant verbalised that nurse have a 'bigger voice in New Zealand'. Relating this to their experiences of nurses' conversations with doctors and how they appeared to be equals professionally in the clinical area on the CAP course, produced several comments and expressions of surprise and fascination, implying that this was not an unwelcome finding for them.

These observations and results corroborate earlier findings of much previous international work regarding the acculturation of migrant nurses (Choi et al., 2019; Goh et al., 2015; Nortvedt et al., 2020). In addition, these responses are consistent with international literature that discusses how doctors in the Philippines and India are likened to gods (Philip et al., 2015; Philip et al., 2019). Similarly, this phrasing is repeated in the interview data obtained in the current research and supported in studies undertaken in Aotearoa (Brunton et al., 2019; Choi et al., 2019). Furthermore, Brunton's (2018) findings describe the slow process of IQNs in Aotearoa becoming aware of the differing power balance they witnessed between medical and nursing staff and then coming to terms with it. Finally, findings from

the current study support previous observations on hierarchy issues in nursing service provision (Bland & Woolbridge, 2011; Woodbridge & Bland, 2010).

Observation of the participants' communication styles during the interviews provided further insight into how they had taken on board this cultural change in professionals working in different ways and how comfortable they felt with it. Notably, more of the Filipino participants were in senior nurse positions. Many Indian participants still displayed some disbelief in the power balance shift from their experiences working as RNs in their home country to how they were working now. They showed shock in their body language and delivered the information with a sense of awe. During the interviews the Indian participants were more hesitant to give information about the CAP course and how it had shaped their nursing since its completion. This trait was also more apparent in the female participants, with the males appearing more comfortable talking. Interestingly, all the male participants had since risen to nurse management positions.

Subservience to senior staff and medical staff has been reported in the Filipino nursing culture (Montayre et al., 2018). This concept could also indicate the more paternalistic social culture in their home country (Ordonez & Gandeza, 2004). However, during the interview processes, the Filipino participants appeared to have managed the change in culture shock faster. As nurses, they appeared more comfortable working in Aotearoa. In addition, they were more confident to give their opinions on why there was a difference in their ability to do make this change. These findings support the conceptual premise of cultural dissonance experienced by the participants during the CAP course in their acculturation into the Aotearoa nursing culture.

International literature supports the premise that difficulty in changes in professional and social cultures has negatively impacted migrant nurses' acculturation to host countries (Högstedt et al., 2021; Pung & Goh, 2017; Valdez et al., 2021). Equally, considerations should also be made regarding the class systems present in India, as there is nothing similar in Aotearoa. When investigating the change in practice and nursing culture, we must consider the difficulty the CAP candidates have in juggling their personal and nursing cultures with the culture shock of learning a new one in such a short and limited programme (Choi et al., 2019). We should also question the ethics of expecting nurses to take on board the new nursing culture and power balance shift to become safe, confident, and competent nurses in a new country and professional working system in such a short course.

Accountability and Responsibility

The research question regarding the participants' perceptions of how the elements of clinical accountability and responsibility for decision-making and assessment skill were covered during the CAP provided insight into their clinical practice experiences during the clinical component. The study participants reported that they had not found the CAP curricula sessions of accountability and responsibility of RNs in Aotearoa to be significant to their learning. Additionally, participants reported that the accountability of RNs in decision making, and care planning was different on the CAP to their previous experience in their own countries; although participants found the patient assessment processes and levels of accountability for their actions to be the same as in their home country. However, many found difficulty adjusting to their increased responsibility for decisions having to be made due to lack of doctors' oversight and governance present in the aged care workplace. Additionally, the Indian nurses described how they felt they had more 'voice' in the decisions made in clinical practice in Aotearoa, which was more critical for them in the CAP clinical area. However, they also spoke of their preceptors on the CAP course who had provided support for healthcare decisions. All agreed that their home country's nursing education had included accountability and responsibility in their nursing roles, but this differed from the Aotearoa professional nursing culture of making critical decisions.

International studies support this concept of limitations of recognising IQNs' autonomy in the clinical area decision-making processes (Stievano et al., 2017; Viken et al., 2018). Additionally, studies report that many IQNs asked for extended orientation to new roles to access more coaching relevant to their practice area (Viken et al., 2018). As discussed previously, during the research interviews, participants expressed that the CAP course clinical practice component was too short and not based on realistic RN roles. Combined with frustrations around the non-recognition of previous nursing experience, there were minimal responses to how well they thought they had learned the Aotearoa way of assessing patients and held the clinical responsibility for their health care decisions. Additionally, due to the practicality of assessing the candidates in a short time frame to obtain information on their competency in the workplace, it would appear that the preceptors had not given over enough responsibility to the participants during the CAP course.

Instead, they maintained their responsibility in running the clinical area and only supported task-focused decisions as part of a clinical supervision role. This reluctance to recognise IQNs' skills and the harbouring of distrust in the host workforce towards IQNs in Aotearoa is identified in several master's theses supporting IQNs in the Aotearoa nursing workforce (Hogan, 2013; Jenkins & Huntington, 2015; Walter, 2017). These researchers highlight a need for clinical supervision and extended orientation programmes for IQNs in Aotearoa. Additionally, sharing of cultural information by both host and migrant nurses combined with an extended orientation period has previously been suggested to employers to affect IQNs entering the Aotearoa nursing workforce (Walker & Clendon, 2012). The research findings from the CAP participants in this study concur with previous studies that show that this extended orientation would positively benefit IQNs. Furthermore, there is a suggestion that ongoing professional supervision may influence future IQNs' better acculturation into the new RN role.

As discussed in the literature review (Chapter 2) and findings (Chapter 7), changing professional cultural differences are significant issues for migrant nurses acculturating to host country systems (Brunton et al., 2020; Chok et al., 2018; Viken et al., 2018). Additionally, the literature review identified issues related to migrant nurses' local societal culture (Nortvedt et al., 2020; Nourpanah, 2019). Cultural safety in nursing has previously been identified as one of the shortcomings for nurses in Aotearoa, focusing on culturally safe service provision as an essential aspect for safe healthcare providers (Papps & Ramsden, 1996). Therefore, the findings from this research on how the participants thought the CAP course prepared them to work with Aotearoa patients and, more importantly, te Tiriti o Waitangi are relevant for future workforce acculturation in Aotearoa.

Cultural safety versus te Tiriti O Waitangi

Research questions on perceptions of the participants' knowledge and use of the concept of cultural safety in nursing and the differences noted from their previous work experiences elicited interesting findings. Additionally, the themes on participant's understanding of cultural safety related to their understanding of te Tiriti O Waitangi and its implementation in health care in Aotearoa provided evidence of how the two sub-themes had become merged in their comprehensions.

A significant finding of the current study was that participant responses to dealing with different patient cultures during the CAP course occurred with notable indifference. Many participants explained how their home country was multicultural, and they felt they were

already confident in their communication to ascertain how to provide safe cultural care for patients. Several participants reported they had attended classroom sessions in their initial nurse education in their home country on social aspects of nursing that they deemed covered the issue of cultural safety. However, there was acknowledgement of the need for more sensitivity to culture in Aotearoa due to the need for specific adherence to Māori patients' wishes. Nevertheless, the participants reported that the classroom sessions and textbooks used on the CAP course did not give real insight into how different the Aotearoa clinical placement experience would be to their prior nursing roles.

Conversely, several participants spoke of how they had found it difficult to immerse themselves in the new cultures encountered on their clinical placement and stated that communication was key in understanding their patients' needs. Additionally, most participants stated they had learned more *after* the CAP course from their employer and other staff members.

The participants' interview data also highlighted their misunderstanding of te Tiriti o Waitangi healthcare provision principles in that they related it only to treating Māori patients. Confusion around differences in concepts around cultural safety and principles of te Tiriti o Waitangi was made evident by their conflation of the two in their interview responses. For example, several participants spoke about how they found the new process of involving patients in their health decisions to be specific to the Māori culture. As a result, there were notable elements of caution in their recollections regarding doing what they identified as 'right' for these patients. For example, an explanation given for why people should not sit on a table was presented as following Māori culture. However, there was a lack of depth to the examples and more focus on the tasks to be carried out for Māori patient care instead of recognition of te Tiriti principles required for nursing service provision. Two participants did recall the 'three Ps' of healthcare provision regarding te Tiriti o Waitangi and recounted that they had learned this on their CAP course.

One explanation for the confusion between the concepts of cultural safety and the principles of te Tiriti o Waitangi may relate to the participants' prior nursing education and cultural experiences. The new experience of consideration of the opinion and wishes of the client, before those of the nurse, regarding nursing care provision, was initially unfamiliar to the participants. This information supports the theory that the change from prior conceptual understandings of professional hierarchy and power balance in the healthcare setting and within the workforce (Choi et al., 2019) was significant in their CAP course

experience. A new way of working with their patients and their colleagues would have become another workforce acculturation issue to contend with during the CAP clinical component. However, there are several possible explanations for these findings. For instance, the perceived fusion of cultural safety concepts into te Tiriti principles indicates that the theory sessions provided on the CAP course were not sufficient to be clearly remembered, nor were they utilised well in their subsequent RN roles. The reports of the brevity of classroom sessions on cultural safety and te Tiriti o Waitangi, combined with the lack of recollections from practice, support the theory that the participants had built on their knowledge base by attending study sessions or asking colleagues in the period after the CAP course.

These results seem to be consistent with the struggles in shifting to different concepts of nursing culture discussed in Choi et al.'s study (2019). Nevertheless, a literature search found nothing related to IQNs and their use or understanding of te Tiriti o Waitangi principles used in nursing practice. However, a discussion around how Aotearoa trained nurses are not confident in using te Tiriti principles in their healthcare provision (Richardson, 2012; Richardson & MacGibbon, 2010) indicates that there may be an issue of transference of this difficulty from preceptor to CAP course candidate. If Aotearoa nurses do not fully understand it, it is unclear how well the IQNs will. Additionally, it may be the case that the power balance shift experienced on the CAP course leads to exhaustion and disempowerment for the learners. There are also similarities with the study by Brunton et al. (2018) when considering the challenging cultural differences for the acculturation of migrant nurses to host country roles. It would also account for the lack of substance given to the theory sessions and the experience in clinical practice in the participants' recollections. In general, therefore, it seems that the CAP classroom sessions on diversity and cultural safety components in nursing were unremarkable and had little utility for participants' subsequent transition into the Aotearoa professional nursing culture and workforce.

Novel Information

The following section examines how the participants regarded the CAP course in its entirety, as obtained from responses to the research question: What were other components seen as satisfactory or unsatisfactory from the CAP experience? In addition, information is included on the participants' reports of the support provided by their

preceptors, the costs of undertaking the CAP course, and the resulting feelings regarding the need for completing it.

Preceptor Support

The research findings show that the preceptor experience was the most significant component of the CAP course for many participants. Descriptions of the relationships occurred spontaneously, and there was a notable increase in positivity when replying to the indicative questions in the interview. In addition, there were reports of both the preceptors and clinical tutors supporting the participants with their language and task performance issues. The relationship between the participant and preceptor was forged in a short time frame yet was often provided as the most positive and fulfilling memory. Finally, participants reported the experience of having supportive staff who encouraged the work and learnings as positively impacting the reduction of difficulties they encountered during the CAP course.

Prior research has noted the importance of preceptors in the acculturation or transition to new nursing roles for migrant nurses (O'Callaghan et al., 2018; Ramji & Etowa, 2018; Zanjani et al., 2018). The focus on providing someone to support a new nurse and show them how the system works is a well-documented concept (O'Callaghan et al., 2018). In addition, Aotearoa studies agree that preceptors and nurse leaders are vital in integrating the IQN into the workforce (Brunton et al., 2020; Hogan, 2013; Walker & Clendon, 2012; Walter, 2017). The findings from this research would support this theory and add to the known and accepted knowledge.

Possible explanations for these findings may be that the CAP course tutors had deliberately recruited clinical placements and preceptors willing to provide this support instead of being seconded into the role. Equally, the nurse managers appeared to have successfully found the best person for the role for each participant. Another explanation may be the participants' a priori cultural views of senior colleagues as having more knowledge and expertise. However, further interpretation of the findings would suggest that the participants focus on finishing the course successfully, combined with a need to find the best person to assist them. Regardless of the reason, this support greatly influenced the success and comfort of the IQN, as demonstrated in participant responses.

CAP and Financial Considerations

Several participants spoke negatively of the length and cost of the CAP course, which was a factor in their view. Their corresponding positive reflections on having successfully completed the CAP course were of interest, although this was opposite to their critical views on value for money. These findings were unexpected regarding the research aim of identifying the usefulness of elements of the CAP course. However, as it is a unique pathway to registration as a nurse in Aotearoa, it is relevant to the overall research findings and discussion. There is no mention of the cost of registration of IQNs in host countries in either international or Aotearoa literature.

As briefly outlined in Chapter 2, the registration costs in Aotearoa were thought to be unfair by some participants and did not appear to relate to the length and content of the CAP. Additionally, discussions about differing costs for domestic and international students prompted critique from participants. There were expressions of anger about the lack of equity in pricing for IQNs with resident visas compared to student or working visas. These are valid points regarding the need for RNs in Aotearoa. It demonstrates how the ability to afford attendance on the course may affect Aotearoa nursing registration applications. Resignment to the cost was a definite factor in some of the participants' discussions. However, as stated, there was considerable pride in having completed the course. It was presented as the accomplishment of becoming a RN in more than one country and the status that brought them.

Differences in the CAP provider period for completion of the clinical practice component and the perceived difficulty of the content was reported as positive by some participants. Several felt the introduction to Aotearoa professional nursing culture was enough to begin their journey into working as an RN and were satisfied with the length and depth of the course. Other participants, however, were critical of what they described as an unnecessary lengthy course considering their prior nursing experience and education. Admission onto the CAP course had taken time, five years for one participant. In addition, the lack of recognition of prior learning for the practical component was still painful for some to recall.

Further consideration of the CAP course costs led to participants' thoughts around equity in CAP candidate selection. As discussed in Chapter 3, candidates for the CAP course are selected from applicants for nursing registration into Aotearoa from designated countries (NCNZ, 2015a), with the highest populations of IQN applicants in Aotearoa currently from the Philippines and India (NCNZ, 2020). These are also the countries identified for requiring CAP course enrolment. Comparison to the migrant nurse registration processes in the USA

(National Council of State Boards of Nursing, 2020) elicited an intriguing participant perspective. Reports of undertaking online exams under the National Council Licensure Examination (NCLEX) system (National Council of State Boards of Nursing, 2022) and obtaining sponsorship for visa applications seemed to be more efficient and less onerous for the participants with this experience.

Summary

This chapter has offered a critical discussion of how the findings addressed the research question, what elements of the current CAP course were significant to the transition to working as RNs in the Aotearoa nursing workforce and compared and contrasted these with the literature.

First it has considered the findings on the participants' social confusion, or dissonance, arising from communication barriers with English as a second or tertiary language. Additionally, this chapter has shown that the different accents, pronunciation, and professional terminology encountered were initially detrimental during many participants' clinical practice component of the CAP. Furthermore, the social acculturation of the participants reportedly improved after the CAP, indicating that their confidence and ability to build on their language skills and use was more significant following completion of the CAP. Moreover, it has presented a critical comparison and contrast of the findings with the international, regional, and national literature on social support and navigating new professional practice (identified in Chapter 5).

Second, it has posited the professional dissonance arising from the differences in nursing practice encountered between the CAP and previous nursing experiences highlighting that the participants found the clinical practice and accountability and responsibility of RN service provision to be similar to their previous experiences in their home nursing workforce, and therefore, was not of any great significance to their transition to working as RNs in Aotearoa. Additionally, discussed has been the barriers presented by the CAP such as feeling being deskilled and devalued by nursing colleagues, by having to undergo a CAP and not being supported to carry out what they felt were 'basic' nursing skills whilst on it. However, differences in the power balance observed in the hierarchy amongst medical and nursing personnel in Aotearoa were shown to be a new and positive experience for some participants and of importance to their CAP clinical experience.

Third, the concept of cultural safety in nursing was seen to have merged with the participant's understanding of the implementation of te Tiriti O Waitangi in healthcare. This confusion was presented as having evolved from the reported short education sessions provided on the CAP combined with a possible of lack of application in participants' subsequent RN roles following the CAP. Therefore, a perception of a lack of significance of the cultural safety and te Tiriti O Waitangi sessions in the curricula and in the clinical experience is evident.

Finally, in answer to the research question of what elements of the CAP were seen as satisfactory or unsatisfactory resulted in the acquisition of novel information obtained about the participants' perceptions of the CAP course. Participants reported that the most significant aspect of the CAP in the transition into the Aotearoa RN workforce for them was the importance of preceptorship and tutor support during the CAP. This aspect was presented and discussed in respect of the Philippine and Indian collectivist social structure influence on their experiences. Findings on participants' perceptions regarding financial and time commitments are presented as considerations of more significant issues in the reported unsatisfactory components of the CAP experience overall.

The conclusion that follows will provide implications and recommendations for IQN transition programmes, clinical practice, policy, and nursing education arising from the key and novel findings, as well as the recognised strengths and limitations of the current research. Finally, it will offer recommendations for future research opportunities.

Chapter 9 Conclusion

Using a qualitative research design drawing on interpretivism, this research aimed to elicit the perceptions of Aotearoa's Filipino and Indian IQNs on how, and if, previous CAP courses had enabled their transition to safe clinical and cultural practice as RNs in Aotearoa. Semi-structured interviews were carried out with purposively sampled IQN participants from the Philippines and India who had previously undertaken a CAP course to obtain nursing registration in Aotearoa. Specifically reviewed were CAP components on RN accountability and responsibility, and participants' understanding of cultural safety in Aotearoa nursing and te Tiriti o Waitangi and its implementation in healthcare provision. Finally, the most significant factors from the CAP course that impacted on IQNs transition into the Aotearoa nursing workforce were identified.

The findings from this focused ethnography have provided an in-depth insight into the participants' impressions of the adequacy of Aotearoa's CAP course clinical practice content in respect of learning new clinical skills, knowledge, and experience in the workplace compared to their previous clinical experience. The findings show that the participants did not recall the learnings about cultural safety in nursing when applied to their clinical practice in Aotearoa; nor did they feel they could accurately define how to apply te Tiriti o Waitangi articles in their healthcare nursing care provision. Additionally, findings showed how the participants benefited from the more symmetrical power balance observed between the medical and nursing personnel in Aotearoa when compared to their home country workforce. Furthermore, most importantly, participants appreciated the support from their preceptors whilst on the course and the ability to access further support and knowledge in the years working as an RN in Aotearoa following the CAP course.

In conclusion, the research has highlighted the need to review the current CAP course curriculum in Aotearoa. Moreover, due to the current global and national RN workforce shortages, decreased nursing migration over COVID-19 and the impact on the workforce of the pandemic, the research findings have significant implications for reviewing the requirement for specifically identified IQNs (Filipino and Indian) to undertake the current IQN RN registration process.

This chapter will initially outline strengths and limitations of the study. Next, it will present recommendations for clinical practice significance for the CAP and future IQN participants and outline possible steps to address these. First, I offer suggestions for changes relating to

the professional practice integration via the CAP course for future presentation to IQNs. Then I will suggest ways to enhance the professional support provided by employers of IQNs. Furthermore, I suggest using in-service opportunities to offer socio-cultural support in the nursing societal context. Finally, I make recommendations for future research.

Research Strengths

Using a qualitative methodology of focused ethnography to undertake this research has enabled in-depth exploration of the information provided by participants within the context of their existing social culture and their acculturation process into the Aotearoa social culture. The methodological approach for each participant to present their views and perspectives during an interview with semi-structured questions has provided a window into their personal journey through the CAP course towards their current role as an RN in Aotearoa. The cultural focus of the methodology has also uncovered why these perspectives are important to the exploration of the sub-cultures of nurses from the Philippines and India, especially the dynamics of their current cultural, social, and professional interactions in the Aotearoa nursing workforce professional culture. In addition, the ability to probe and tease out responses have provided in-depth descriptions of the cultural elements of the participants' understandings. Finally, using a focused ethnography that gains rich in-depth cultural data obtained from participants enables presentation of details that were previously uncovered. In this research, the new professional power balance, and the support from preceptors, are valuable insights for future consideration of cultural collectivist social structures, as compared with the Aotearoa individualist social structure.

Research Limitations

At first, there were difficulties recruiting participants for interviews, resulting in a review of the recruitment process. Initially, posters were distributed to, and pinned on notice boards of, aged care nursing workplaces where IQNs are most commonly employed. However, this elicited minimal response. This may have been for reasons of the preconceived cultural perceptions of the sample population—IQNs in aged care working as RNs—as they may not have considered they could provide any pertinent information. Additionally, Filipino, and Indian nurses can be hesitant to engage in research, as confirmed in the pilot interview; hence, the practice of explaining the research in more detail at first contact with potential recruits ensued.

Secondly, as discussed in Chapter 3, there was a challenge in the cultural perceptions of the researcher being in a position of power imbalance to that of the participants (i.e., a senior nursing position). There is a cultural bias regarding hierarchy in the Filipino and Indian social and nursing professional standing. Therefore, the participants' underlying cultural influences may have determined their attitudes and responses to the researcher. For example, participants may have perceived me as being of a higher hierarchical level due to my seniority as a doctoral candidate and my confidence in the approach for organising interviews to obtain the data. It could also be argued that the participants' awareness of my position as investigating their perceptions of the CAP course could have influenced their responses as they may have family or friends wishing to attend a future course.

To address this perception, I attended at staff meetings in aged care facilities during September and October 2018 together with politely requesting nursing managers and senior nurses to highlight the poster to whomever they deemed suitable candidates for the research. These meetings provided me with a means of explanation of the remit of the research and assurance of anonymity of responses. Interestingly, many of the clinical managers approached were Filipino. They supported my intent to carry out a study to investigate the significance of the CAP course content for its participants. As a result, there were more Filipino respondents after the managerial recommendation to participate, and some of the participants who asked to be included in the interview process were the same managers approached for support.

Furthermore, to increase the research participant population base, the geographical area was expanded from the Northland area of Aotearoa to cover the city of Auckland with its greater population of nurses and healthcare settings. These previously considered and ethically supported changes in recruitment processes, combined with the word-of-mouth referrals from initial participants, provided the required number of participants to obtain substantial and informative data for review and interpretation.

An additional limitation to this research is in presenting my interpretation of the perceptions of two cultural groups of IQNs living and working in Aotearoa as RNs, as undertaken using a qualitative focused ethnography methodology. Any information obtained was organised into themes constructed by interpreting the data using my personal understandings and experiences. Therefore, acknowledgement is made that my interpretations could be viewed differently by other researchers. As such, participant

quotes, including their coding and relevance to subsequent themes, were included and offered as evidence of interpretation.

Finally, although providing in-depth participant data, the study sample size and limited regional recruitment site may not be consistent with the views of the wider Filipino and Indian IQN RN population in Aotearoa; for example, Auckland, where most IQNs work. Nevertheless, although it was never the intention, a deep, rich insight has been provided on a pivotal workforce area. It is acknowledged that a nationwide investigation of Filipino and Indian IQNs' experiences may offer a broader range of data regarding the CAP course provision and undertaking. However, the participants interviewed accessed the CAP course in different locations around Aotearoa and had since moved into the Northland and Greater Auckland area, providing information about CAP courses over the North and South Islands.

Recommendations

The findings provide unique and novel insights into this cohort of Filipino and Indian IQN participants' initial registration onto educational transition programs (CAP) and later clinical experiences in the Aotearoa nursing workforce. Previous international studies have shown how IQNs face challenges transitioning to the host country's nursing workforce. However, the predominant focus examined their ongoing transition and acculturation, and did not examine the initial assessment of the IQNs' abilities prior to registration. Whilst this research identified similar themes to these studies regarding the transition of IQNs to a host country workforce, such as communication and professional socialisation it also provided unique and novel insights Therefore, the timely result of this study can be utilised to propose recommendations on reviewing the current IQN registration process and ongoing transition into the nursing workforce in Aotearoa with implications for education providers, the NCNZ, employers of IQNs and the Aotearoa public .

Three main recommendations are presented arising from the research findings that illustrate a need to review the current a CAP course, with additional recommendations for ongoing support for IQNs via a programme of recontextualising nursing practice to enable integration into the Aotearoa nursing workforce.

Professional Practice

Improve the Clinical Practice Significance

The first recommendation results from participants not being able to identify significant new learnings in the nursing practice and task completion undertaken on the CAP course

compared to their prior clinical experiences. Instead, they reported the main differences from exposure to unfamiliar technical jargon and their observed differences noted in the more egalitarian hierarchy of professionals in the clinical area than in their home workforce. This is a common theme in international literature and this research supports the concept. Furthermore, participants encountered confusion around the 'new' role of the NZRN and were inhibited from undertaking clinical skills they had previously been trained to do, such as IV medication administration. In addition, the participants did not gain a robust understanding of the NZRN role regarding accountability and responsibility (e.g., clinical decision-making for patient treatment), as they were excluded from using these whilst on the course. Instead, due to their nominated roles as 'RNs under supervision' by each clinical placement area, and self-identification as 'students' on the CAP course, they relied on preceptors' support and agreement with their decisions. Moreover, some of the participants' focused on professional task completion, when reporting the differences and similarities in their professional practice, highlight a continuing inability to work autonomously and employ a patient centred approach in their current RN roles, such as following set processes in surgical theatres and following set procedures in renal dialysis with minimal recognition of the holistic assessment skills used for determining abnormal symptoms. In conclusion, the CAP course nursing knowledge content was not seen as significant to these participants regarding their subsequent registration as RNs in Aotearoa.

Perhaps more importantly, the need to complete a clinical component for the CAP course to be assessed as 'safe' and 'competent' in their nursing practice had caused feelings of humiliation for some of the participants. As discussed in Chapter 2, the participants had to have completed a four-year degree in nursing and worked for two years as an RN before being accepted into the CAP course. Therefore, it can be assumed that the acculturation process into the Aotearoa nursing workforce experienced by the participants had several 'false starts' due to their feelings of exclusion and culture shock whilst undertaking the CAP course. In addition, due to the change from classroom nursing knowledge sessions to moving to clinical placement, the participants needed to adjust to different people and unfamiliar workforce systems and protocols. Therefore, the participants would have experienced discomfort and instability in their roles, and this may have negatively affected their ongoing transition into the new nursing workforce.

Additional information obtained from the participants regarding their perceptions of unsatisfactory elements of the CAP included negative views of time and financial commitments required to undertake the CAP course. In particular, reports of

disappointment with the high cost, short duration, and queries of their need to do it to obtain RN registration in Aotearoa were the salient concerns reported by the participants. This information provided insight into previous and current CAP curricula and cost for the participants which supports recommendations for a review of the CAP pathway process, to include a revision of the need for a clinical practice component.

The findings from this research provide supporting evidence for the following recommendations for the review of the current CAP course in light of the recent extra demand on nursing recruitment due to the COVID-19 pandemic. With decreased migration of nurses due to the limited ability to travel internationally in response to measures to contain and manage the epidemic, less opportunities have been available for healthcare professionals to move from their home country. Additionally, like many other countries globally, Aotearoa faces an acute and predicted severe nursing workforce shortage. Lessening the time period of the CAP while at the same time introducing step by step integration into Aotearoa nursing practice might produce a more streamlined and effective reintegration for IQNs.

Reliance on the recruitment of IQNs has historically been the solution to the workforce shortage. However, IQN recruitment sources have changed over the past decade, and nurses from Asian nations are now the primary recruitment source, with the numbers of nurses migrating from the UK decreasing (see Chapter two). Constituting the largest ethnic populations of IQN seeking registration, nurses from the Philippines and India currently can only obtain registration after assessment from a CAP course due to considered differences in their initial nursing education and role expectations. The findings from this research imply that Aotearoa has a professional cultural bias (ethnocentric bias) of seeing Filipino and Indian IQNs as having different, or often less, nursing knowledge and skillsets than their own NZRNs.

Consequently, the current CAP course does not provide take into account participants' prior nursing and life experience. Furthermore, the NCNZ supports this consideration of cultural and clinical practice differences in its requirements for the RN registration process in mandating that overseas educated nurses from the Philippines and India undergo a CAP course, without requiring IQNs from the USA, UK, and Australia to do so the same. Additionally, the research findings show that the Filipino and Indian IQN participants felt deskilled and devalued on the CAP course and questioned its process and relevance to their need to register and work as an RN in Aotearoa. Therefore, it can be argued that the CAP

course was detrimental to assessing the participants' safety and competency in a registered nursing role as aspects of their previous skills and experience were ignored and even inhibited. Furthermore, the use of aged care facilities for assessment processes used during the CAP clinical component minimised the opportunity to provide evidence of the participants' competency in what they considered as basic nursing skills, thereby leaving many dissatisfied and dismissive of their competency assessment completion.

The research findings further show that the CAP course assessment process was seen to be delivered differently by educational providers in Aotearoa whilst all still adhering to the NCNZ standards. These differences affected the CAP related experiences of the research participants. Their examples revealed how they had different curriculum information delivered and that their practical clinical experiences differed in complexity due to the clinical area used. Consequently, it can be argued that the CAP course's non-standardised assessment of the participants' safety and competence regarding the forthcoming role as RNs in the Aotearoa nursing workforce is not an accurate method for confirming this for the IQNs undertaking it. In support of a review of the current IQN RN registration process in Aotearoa, the following recommendations are made to suggest possible changes and review the need for IQNs from the Philippines and India to undertake a specific course to obtain registration.

In light of the research findings, it is highly recommended that the current CAP course is comprehensively evaluated at a minimum. Therefore, it is recommended that the NCNZ consider a nationwide review of the policy underpinning the registration process. Furthermore, it is suggested that this review should be undertaken in consultation with the CAP education providers so that any agreed changes to the CAP and its pathway process are implemented nationally. In addition, stakeholders in the employment sector for RNs may be invited as an additional party in the consultation process as many may have specific educational requirements for IQN RNs in their employment. This review of the current CAP would provide a national agreement for future provision and for standardising or revising the current curricula as this has not occurred previously. Finally, changes to the NCNZ policy of requirements for a clinical practice component would improve the practical and time-based barriers for IQNs.

Suggestions for discussion as part of the national NCNZ led CAP course review are as follows:

1. Review and standardise current CAP course content –
    - Ensure all education providers use the same national curricula and nursing knowledge content.
    - Implement a national nursing key transition knowledge and skills examination for IQNs.
    - Remove the clinical practice assessment component requirement and replace it with an OSCE assessment of direct observation of IQNs' performance in a scenario-based situation.

The research findings also pointed to the minimal impact of the clinical practice component on IQNs knowledge gain and subsequent integration into the roles as RNs. This research, therefore, recommends replacement of the CAP in its current form with the following:

2. Alter IQN RN registration pathway process –
    - Remove the need to complete a CAP course. Instead, combine current prerequisite eligibility criteria requirements with less complex processes.
    - Ensure that IQNs successfully complete two online exams, one on nursing knowledge theory, and another on medication calculations and administration.
    - Require IQNs to complete an OSCE examination with a registered provider within six months of commencement of employment as an RN. This employment could occur as an apprenticeship as an RN under supervision or with an advanced healthcare assistant role (as in the UK's current IQN RN registration process, see Chapter 2).

Need for targeted te Tiriti o Waitangi education

The content of the CAP course learnings and clinical placement had not provided an acceptable interpretation of the principles of te Tiriti o Waitangi to use for delivering healthcare provision. This knowledge gap was evident on several occasions where the two

concepts were amalgamated in participant responses and were specifically described as tasks to be completed for Māori patients. Therefore, the apparent lack of participants' understanding and current recollections of the Tikanga provision above consideration of te Tiriti provides evidence of a need to review and revise Te Tiriti education and implications for healthcare provision provided on the CAP course for IQNs.

Therefore, in addition to the suggested changes to the CAP pathway process, as outlined above, it is recommended that all IQN candidates attend a mandatory te Tiriti o Waitangi education and training session within six months of commencing work as an RN or online at the point of registration (similar to Australia's IQN RN registration process, outlined in Chapter 2).

Need for Socio-cultural Support

Communication and Professional Support. The following recommendations arise from the findings that highlighted participants' confusion with communication and the new RN role expectations. The participants all experienced various personal and professional language barriers to communication, including difficulty in understanding local Aotearoa accents. Requests from patients led to confusion about the nursing input required. Communication difficulties occurred when encountering a new cultural experience with less professional hierarchies of authority than they had previously known. This experience led to confusion about approaching and addressing the doctors and senior nursing staff. However, differences in the power balance observed in the hierarchy amongst medical and nursing personnel in Aotearoa were shown to be a new and positive experience for some participants and of importance to their CAP clinical experience. Finally, as some participants stated, the CAP course did not represent 'real life' as an RN in Aotearoa. However, all participants described how their assigned clinical preceptors had supported them to adjust and looked after them. Moreover, all described that adjustment to language and expectations of working as an RN in Aotearoa occurred in the years following their CAP course.

The research findings strongly indicate that having a preceptor greatly influenced the participants' experiences of feeling welcomed and supported during the CAP course. As described in Chapter 5, these findings also support the international literature on the successful acculturation of a nursing professional into a host country's workforce. Therefore, recommended strategies for supporting IQNs in the workplace post registration include:

1. Provision of a preceptor support system with a designated 'Buddy' for mentorship to introduce and familiarise the clinical area and employer expectations.
2. Implementing a mandatory extended orientation for IQNs in the workplace to support safer and more supportive acculturation into the Aotearoa professional nursing culture through employer provision.
3. Extended preceptorship through regular, ongoing professional supervision from senior nurses in the clinical area or by accredited nursing professionals after the orientation period.

Enhance Professional Socialisation. Other recommendations for future IQNs in their transition into the Aotearoa professional nursing culture occur in the social context. As shown in Chapter 4, the use of language and the ability to communicate greatly enhances the acculturation of IQNs into a host country. Therefore, the following recommendations are made to support IQNs and limit culture shock to enhance their social integration.

1. In addition to the difficulties faced with the language and newly introduced RN roles in the clinical areas, the participants found the Aotearoa professional nursing culture different regarding professional hierarchy and the 'way things were done'. Therefore, implementing mandatory cross-cultural education/training for newly recruited IQNs and Aotearoa educated RNs in the workplace via online modules offered by NCNZ or Immigration New Zealand could support the breakdown of barriers to interprofessional interactions and conflicts. In addition, IQNs could learn specific professional language and collaboration techniques to use in the workplace to enhance their acculturation into the Aotearoa nursing workforce and healthcare systems.

Suggestions for implementation are:

1. Employers of IQNs could provide ongoing workplace events where each cultural group of nurses can present their home country's culture and belief systems. These events could include sharing culturally identified food and the celebration of different festivals or traditions, with education about their meaning and importance. In addition, these sessions would provide two-way learning of the cultures of each ethnicity.

2. Ongoing in-service sessions with quizzes using local colloquialisms and jargon could be introduced in the workplace to foster ongoing collaboration, appreciation of diversity, and mutual respect and understanding.

Recommendations for Future Research

The findings from this study provide context for future research possibilities into IQN acculturation into Aotearoa. One approach could be to evaluate the barriers and enablers to IQNs, from other ethnic workforce groups such as IQNs from the UK, USA and Canada who have transitioned into the RN role in Aotearoa without undergoing a CAP course. This research could provide insights into how these IQNs adapt to the Aotearoa professional nursing culture expectations around cultural safety, and implementation of te Tiriti o Waitangi into their healthcare provision. Additionally, it could provide evidence on how well these IQNs were supported in their new roles and how this support had been provided.

Further research suggestions include quantitative and qualitative investigations into how patients and allied health professionals, including specialist nursing roles see the enablers and barriers to integration of IQNs into the Aotearoa health workforce.

Finally, a recommendation for qualitative research into the role of preceptorship, such as the key components and barrier and enablers to sustaining this in supporting and guiding IQNs to transition into the Aotearoa nursing workforce could provide insights into the benefits and challenges for the preceptors and the IQNs. Such evidence combined with input from allied stakeholders- nursing educational providers, nursing employers and practising clinical preceptors regarding patient satisfaction surveys and workforce management surveys, could, in turn, provide a curriculum model for preceptorship education, including professional supervision content in Aotearoa. As with the recommended national CAP review, it would be beneficial to involve all nursing education providers in the study to formulate a national curriculum for future preceptor education and study provision.

Summary

The process of acculturation of IQNs into a host country's nursing workforce is vital to health outcomes, and their care is of pivotal importance. Safe and competent nursing care affects medical care provision and population health outcomes. This current study has focused on Aotearoa's current CAP course content and IQN RN registration process. Key findings highlight that the CAP clinical and cultural component elements had not sufficiently supported the transition into the RN workforce nor significantly influenced the Filipino and Indian IQN participants' nursing practice in Aotearoa. However, preceptor roles were highly valued, as was the redress of professional power symmetries and seen as the most enabling aspects of the CAP.

This chapter has included recommendations for a comprehensive review of the current CAP course curriculum to address the issues in assessing the IQNs' safety and competency in nursing knowledge, culturally safe care provision and adherence to the healthcare principles of te Tiriti o Waitangi. In addition, it has recommended a review of the IQN RN registration process overall. Furthermore, in recognition of the differences in IQNs' collectivist cultural perspectives from Aotearoa's individualist context it has recommended enhanced professional support in the orientation period with mandatory ongoing professional supervision for IQNs.

These recommendations would benefit the IQN nursing profession and enhance patient safety and care through improved communication, cultural assimilation, and appreciation and respect and attention to the richness and diversity of the cultural background of IQNs by host country nurses.

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Appendices

Appendix A: Request for Information

From: Pam Doole Pam@nursingcouncil.org.nz
Sent: Wednesday, June 5, 2019 4:06 PM
To: Anne Clubb aclubb@northtec.ac.nz
Cc: Ana Shanks <Ana@nursingcouncil.org.nz>; Kalpana Jayanatha Kalpana@nursingcouncil.org.nz
Subject: Request for info please

Hi Anne
Ana has passed your query to me. I have been able to locate some Council minutes and policies that indicate that some IQNs whose programmes were not considered equivalent to a NZ nursing programme were required to do up to 3 months supervised experience with instruction in an employment setting or a learning environment in 1996. I can't see anywhere that the content of the "instruction" was specified.

The Trans-Tasman Mutual Recognition Act 1997 and "at least two instances where standards of competence have been demonstrated to be inadequate" as well as issues of fraudulent papers from the Philippines led the Council to begin working with Polytechnics interested in providing programmes for overseas applicants to develop national guidelines for programmes to be approved by Nursing Council (Minutes Nov 1998).

The policy was changed in May 1999. See this extract from the May 1999 minutes:

9. Council approval and accreditation of programmes/courses set up to assess the ability of overseas nurses and/or midwives to meet the competencies.

10. Programmes for applicants for registration from overseas be approved by Council and comply with the minimum requirements outlined in 5.1. (I can't find this policy paper)

10.1 Educational institutions specified in the schedules of the Nurses Regulations 1986 and Amendments may develop programmes.

10.2 An integrated theory and practice assessment of each individual applicant is required.

10.3 Minimal requirements for programmes for applicants from overseas are:

· Introduction to the New Zealand Health Care System;

· Introduction to Cultural Safety in Nursing/Midwifery;

· Statues and regulations impacting on the practice of nurses and midwives in New Zealand;

· Appropriate clinical placements.

10.4 Proposed programmes must demonstrate how the Competencies for Entry to the Register Nurses or Competencies for Entry to the Register Midwives are to be met.

10.5 Nursing Council approval of each individual programme is required.

I hope this answers your question

Kind regards

Pam

Pam Doole | Director of Strategic Programmes

Te Kaunihera Tapuhi o Aotearoa | Nursing Council of New Zealand

PO Box 9644, Wellington 6141 | Level 5, 22 Willeston St, Wellington 6011

DDI: +64 8021324 | **Fax:** +64 4 801 8502

Website: www.nursingcouncil.org.nz

From: Anne Clubb <aclubb@northtec.ac.nz>
Sent: Monday, 27 May 2019 12:33 PM
To: Ana Shanks <Ana@nursingcouncil.org.nz>
Subject: Request for info please

Hi Ana
Thanks for your assistance last week J

I wondered if you could help me with another query? For my research, I was looking to find some info on the initialisation of the CAP in NZ and the history behind it. I can't find anything in the literature and wondered if there was anything at Council that I could access to see how and when the CAP was set up? It would be useful background to my discussions re IQN requirements and how these were arrived at.

Thanks

Ngā mihi

Anne Clubb
Nursing Lecturer

Programme Co-ordinator

CAP programme and RN Return to Nursing

Outcomes - Social & Community Services Pathway - Nursing

NorthTec
***P:** +64 (9) 470 3665 **M:** +64 (27) 555 4562*

Appendix B: Research Flyer

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

ARE YOU AN INTERNATIONALLY QUALIFIED NURSE (IQNS)

FROM THE

PHILIPPINES OR INDIA

WHO HAS COMPLETED A CAP COURSE

BEFORE 2016 AND

WHO HAS BEEN WORKING AS A RN?

You are invited to take part in research about the CAP course and how it supported you to work in New Zealand as a registered nurse.

Please contact Anne Clubb for more information
anne.clubb@yahoo.com or phone – 021 865432

Appendix C: Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

27 July 2018

Project Title

Internationally Qualified Nurses' perceptions of how the New Zealand Registered Nurse Competency Assessment Programme enabled transitions to clinical and cultural practice in New Zealand

An Invitation

My name is Anne Clubb and I am a nurse educator currently employed at NorthTec, Whangarei. I would like to invite you to participate in a research project, that is being undertaken as part of a Doctor of Health Science (DHSc) degree program. Participation in this research project is on a voluntary basis and based on informed consent. You have the right to withdraw from participating in the project at any time prior to the completion of the data collection.

What is the purpose of this research?

The study looks to research the meanings and understandings gained by IQNs who have completed the CAP course, and how they have used the learnings from it to enrich their experience and work with clinical and cultural safety as registered nurses in New Zealand.

The results from the research will be written in the form of a doctoral thesis and the findings may be shared through journal articles and conference presentations nationally and internationally.

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

I am seeking volunteers from Northland who initially gained their nursing qualifications in the Philippines or in India, and who successfully completed a CAP programme at least 2 years' ago and have been working as a registered nurse since. Nurses who have completed a shortened nursing degree in New Zealand or who have not worked as a registered nurse since completion of the CAP do not meet the criteria for the study. Nurses known professionally to me will not be invited to participate as this may give bias to the findings.

How do I agree to participate in this research?

Please contact me in you are interested in becoming a participant. Agreement to participate will be obtained by completing a written informed consent when we meet for interview.

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 potentially identifiable 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.

What will happen in this research?

If selected as a participant in the research, we will meet face to face for a discussion that will identify whether you wish to participate in a focus group or provide a face to face interview. Both will take approximately 60-90 minutes each and it will be your choice which one you want to use to provide the information required for the research. You will be asked to share stories and experiences from your work as a registered nurse and to identify, if you can, whether there were any links to your learnings from the CAP course. The group or interview will be audio recorded and transcribed by a professional transcriber who will have signed a confidentiality agreement. You will be given the opportunity to review and approve the transcript for inclusion in the study.

What are the discomforts and risks?

There may be some points in the process where you feel some discomfort in discussing your experiences. You are advised to choose the stories or experiences that you wish to share to minimise the discomforts or risks.

How will these discomforts and risks be alleviated?

You are advised to seek support from your manager or workplace employer support services if you experience discomfort or feel at risk from sharing your experiences.

What are the benefits?

The research has the potential to support you in your work as a registered nurse as it will be a reflective process on your experiences.

How will my privacy be protected?

Your identity will remain confidential to the researcher who will store your contact details securely, to maintain your privacy. Care will be taken to ensure that your identity cannot be determined from your shared information and private settings will be used for the interview. You will be sent the transcript from the interview to check and you are supported to request for any information to be deleted at that time.

What are the costs of participating in this research?

The interview will take between 60 – 90 minutes of your time to complete. I will endeavour to conduct the interview at a time and place that is suitable and convenient for you. A contribution to travel costs incurred to attend the interview will be reimbursed with a $20 petrol voucher.

What opportunity do I have to consider this invitation?

Please reply to this invitation within four weeks from the time of receipt of this sheet. I will make a follow up call to you if I have received no response to the invitation within this time frame. If you would like to participate in the study, please contact me at the email address or telephone number below. Please don't hesitate to contact me if you have any questions about the study before you agree to participate.

Will I receive feedback on the results of this research?

If you have indicated that you wish to receive feedback on the results of the research, I will send you a written report on completion of the study.

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, Professor Eleanor Holroyd, eleanor.holroyd@aut.ac.nz 09 921 9999 ext 5298

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 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:

Anne Clubb; aclubb@northtec.ac.nz 09 4703665

Project Supervisor Contact Details:

Professor Eleanor Holroyd, eleanor.holroyd@aut.ac.nz 09 921 9999 ext 5298

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.

Appendix D: AUTEC Approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

17 September 2018

Eleanor Holroyd
Faculty of Health and Environmental Sciences

Dear Eleanor

Re Ethics Application: **18/328 Internationally qualified nurses' perceptions of how the New Zealand Registered Nurse Competency Assessment Programme enable transitions to clinical and cultural practice in New Zealand**

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

Your ethics application has been approved for three years until 17 September 2021.

Standard Conditions of Approval

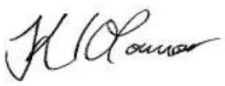
1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/research/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available 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. 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

Yours sincerely,



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

Cc: anne.clubb@yahoo.com; Priya Saravana-Kumar

Appendix E: Demographic Information

Demographic Information

Project title: Internationally qualified nurses' perceptions of how the New Zealand competency Assessment Programme (CAP) enabled transitions to clinical and culturally safe nursing practice in New Zealand

Project Supervisors: Professor Eleanor Holroyd, Dr Priya Saravanakuma

Researcher: Anne Clubb

Please answer the questions below

Are you?
Male □ Female □ Prefer not to answer □

What age range are you in?
20-25 □ 26-30 □ 31-35 □ 36-40 □ 41-45 □ 46-50 □ 51-55 □ 56-60 □ 61-65 □

What is your ethnicity?
Indian □ Filipino □

How long have you been a Registered Nurse in New Zealand?
1-5 years □ 5-10 years □ 10-15 □ 15-20 □ 20+ □

Where did you first qualify as a Registered Nurse?
Internationally Qualified in India □ Philippines □

What geographical area do you work in?
Northland □ Auckland □

What nursing area do you work in?

.....

Where did you complete your CAP course?

.....

Appendix F: Consent Forms

Consent Form

Project title: ***Internationally Qualified Nurses' perceptions of how the New Zealand Registered Nurse Competency Assessment Programme enabled transitions to clinical and cultural practice in New Zealand***

Project Supervisor: ***Professor Eleanor Holroyd***
Researcher: ***Anne Clubb***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 28 July 2018
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that 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 type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

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

27 July 2018

Consent Form

Project title: ***Internationally Qualified Nurses' perceptions of how the New Zealand Registered Nurse competency Assessment Programme enabled transitions to clinical and cultural practice in New Zealand***
Project Supervisor: ***Professor Eleanor Holroyd***
Researcher: ***Anne Clubb***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 28 July 2018.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ 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 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, while it may not be possible to destroy all records of the focus group discussion of which I was part, 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 type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

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

Appendix G: Interview Questions

Project title: Internationally qualified nurses' perceptions of how the New Zealand Competency Assessment Programme enabled transitions to clinical and culturally safe nursing practice in New Zealand

Project Supervisors: Professor Eleanor Holroyd, Dr Priya Saravanakuma

Researcher: Anne Clubb

Specifically, the study will aim to answer the research question:

What elements of the current NZ Competency Assessment Programme (CAP) were useful to Internationally Qualified Nurses' (IQNs) transition to working in New Zealand following successful completion and subsequent registration?

Indicative questions for the interview are:

1. How did feel to be practicing as a registered nurse in New Zealand after completing your CAP course and receiving your annual practicing certificate?

2. How did the cultural safety component in the CAP course prepare you for working in New Zealand?
    a. How did it feel to have to adjust to different cultural groupings of patients?
    b. How well did you understand how the Treaty of Waitangi was relevant in your nursing service provision?
    c. What specific nursing provision did you provide that you can relate to the learnings from the cultural safety component of the CAP course?

3. How did the clinical practice component covered in the CAP provide understanding of -
    a. Clinical responsibility
    b. Accountability and decision making and
    c. Assessment skills

    required in NZ healthcare planning as a RN?

4. How does your professional practice differ now from that in your country or origin?

5. What things can you remember specifically from the CAP that helped you to understand how to practice as a RN in New Zealand?

Appendix H: Confidentiality Agreement

Project title: Internationally Qualified Nurses' perceptions of how the

New Zealand Registered Nurse Competency Assessment Programme enabled transitions to clinical and cultural practice in New Zealand

Project Supervisor: Professor Eleanor Holroyd

Researcher: Anne Clubb

✓ I understand that all the material I will be asked to transcribe is confidential. I understand that the contents of the tapes or recordings can only be discussed with the researchers.

O/ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

.....

Transcriber's name: Erika Gajdocsi

.....

Transcriber's Contact Details (if appropriate):

021-236-1408

erika@nztranscriptions.com

Date: 28/02/2018

Project Supervisor's Contact Details (if appropriate):

Professor Eleanor Holroyd

School of Health Care Practice

Faculty of Health and Environmental Sciences

AUT University

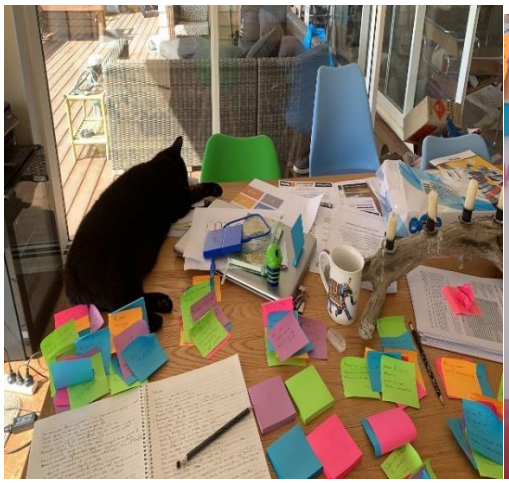
Eleanor.holroyd@aut.ac.nz

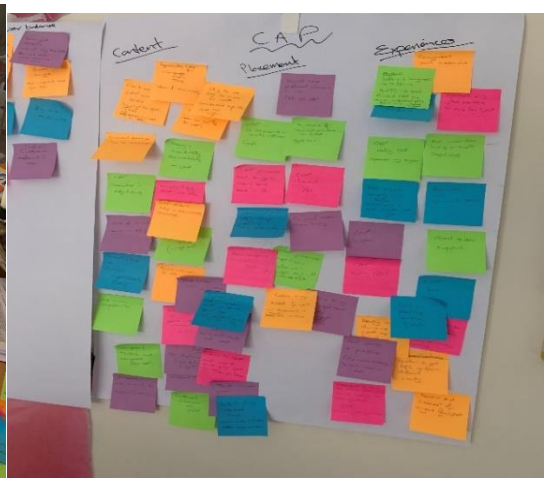
09 921 9999 ext. 5298

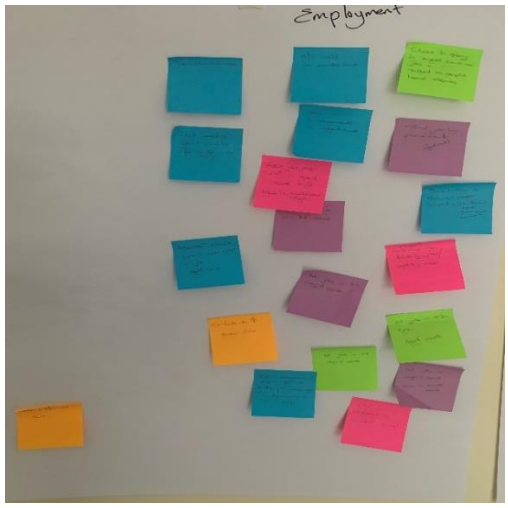
Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

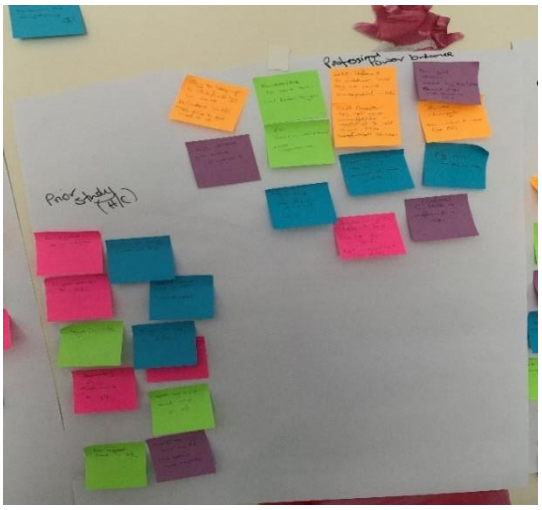
Note: The Transcriber should retain a copy of this form.

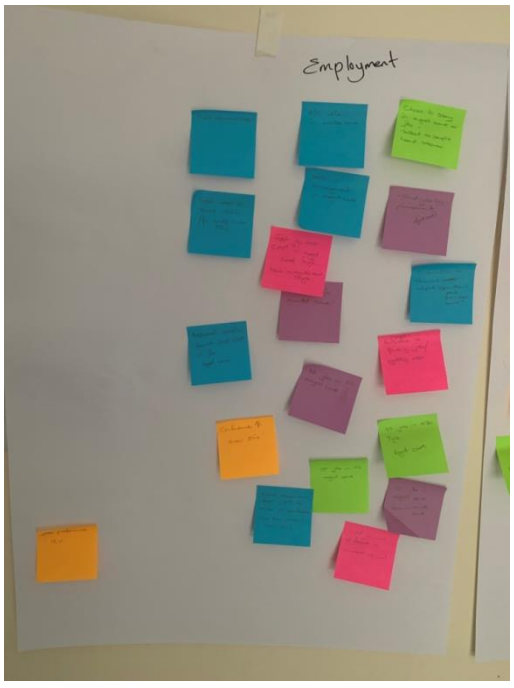
Appendix I: Coding process with Post-it notes (and helper 😊)

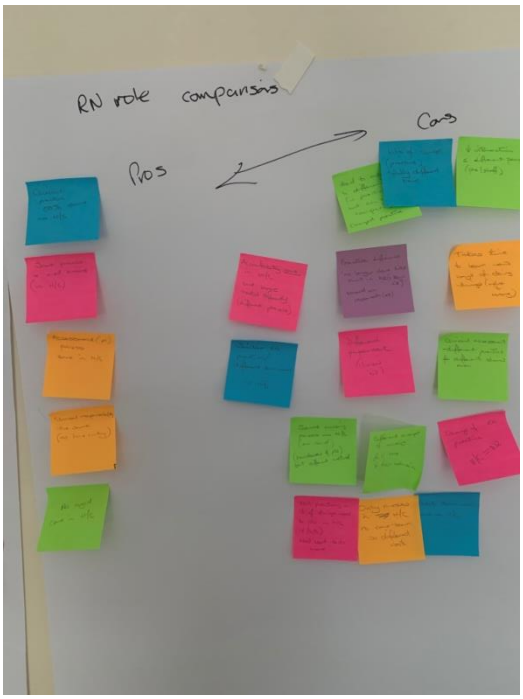












Appendix J: Analysis on the Whiteboard