

**Internationally Qualified Nurses' Perceptions of  
Patient Safety: New Zealand Case Studies**

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## **Abstract**

Twenty five percent of the current New Zealand nursing workforce comprises internationally qualified nurses (IQNs). For a significant proportion of IQNs, English is an additional language and the social, cultural and historical context of the health systems from their country of origin differs significantly to that of New Zealand. International studies have found that despite many of these IQNs having extensive nursing experience prior to entering a new country, the challenges involved with transition can have implications for patient safety. This study aimed to investigate IQNs' perceptions of the competencies that pertain to patient safety. The study was informed by an interpretive-constructivist approach that acknowledges these perceptions are constructed within a social, cultural, and historical context. A qualitative multiple case study design was used with the Communities of Practice (CoP) theory as the conceptual framework. The primary data source was semi-structured interviews with four IQNs while they attended a Competency Assessment Programme (CAP) to obtain New Zealand nursing registration. The IQNs' email reflections and programme documents were used as additional data. Thematic analysis of the individual cases followed by cross-case analysis revealed similar perceptions concerning patient safety across the four cases. Exposure to Nursing Council of New Zealand's (NCNZ) competencies for safe nursing practice during the CAP course did not notably change the participants' initial perceptions. The most significant finding of this study was that the social, cultural, and historical context of the health system and nursing role mediates how maintaining patient safety will be perceived and enacted in practice. The findings also highlighted the importance of engaging with participant perspectives in order to identify specific areas required for learning and transfer of information. These findings had important implications for further development of educational and healthcare agency support for IQN transition.

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# **Chapter One: Introduction**

## **Introduction**

Expanding and aging populations, coupled with nursing shortages, have created the drive for recruitment of internationally qualified nurses (IQNs) in countries such as New Zealand (NZ), Australia, Canada, United States, and the United Kingdom (Habermann & Stagge, 2010). In NZ, 25% of registered nurses are IQNs. The three largest ethnic groups identified in this workforce are 'Other European' (39%), Filipino (23%), and Indian (20%) (Nursing Council of NZ, 2015). In 2007, 15.5% of nurses working in Australia were IQNs (Muller, 2014). Collectively, the Organisation for Economic Cooperation and Development countries had an average of 10.7% of IQNs in their nursing workforce in 2000, with numbers increasing (Yeates, 2010). The literature in this study relates to IQN migration to the aforementioned nations.

For a significant proportion of IQNs, English is an additional language and the social, cultural, and historical context of the health system from their country of origin differs significantly to the country they are entering. The challenges of transition for these IQNs are highlighted in literature (Xu & He, 2012) and despite many of them having extensive nursing experience (Peisachovich, 2015) it has been found that these challenges can have implications for patient safety (Xu & He, 2012). Yet, research in this field is limited (Lum, Bradley, & Rasheed, 2011; Woodbridge & Bland, 2010).

## **Research aim and approach**

Patient safety and safe nursing practice are central to healthcare. This research aimed to explore IQNs' perceptions of the competencies that pertain to this core nursing concept. The social, cultural, and historical contexts of the IQNs were explored through interviews and reflections to gain insight into how these perceptions were constructed. It was anticipated that exploring these perceptions would help inform educational and healthcare sector support for IQNs through the transition process.

This research used a qualitative multiple case study design informed primarily by Merriam (2009) and Yin (2014). The data from four IQN participants undertaking a Competency Assessment Programme (CAP) course were gathered through

interviews, reflections, and document analysis. Data were analysed using communities of practice (CoP) theory (Wenger, 1998). The CAP course itself was not the focus of the study; rather, it provided the opportunity to recruit IQNs encountering the transition process, using purposive sampling. As a secondary focus, however, the impact that exposure to the Nursing Council of NZ (NCNZ) competencies (embedded in the theoretical component of the course and in clinical placements) had on IQNs' perceptions of patient safety was examined.

### **Positioning myself as researcher**

Merriam (2009) promotes the sharing of information in qualitative studies pertaining to the researcher's background and philosophical orientation to provide the context in which a study has been based. "Researchers bring their own world views, paradigms or set of beliefs to the research project" (Creswell, 2007, p. 15), and therefore interpretation is shaped by experience and background. My nursing career has spanned three decades. In the latter part of my career I became the nurse educator in an Emergency Department where I mentored new staff in their transition from novice to competent and competent to expert practitioners. Amongst these new staff were IQNs with English as an additional language and from healthcare systems very different to that of NZ. These IQNs were employed as NZ registered nurses in my area having already completed the Nursing Council requirements for entry to the NZ nursing register and undertaken a CAP course prior to their employment. These IQNs had prior nursing experience and were highly motivated to learn. Despite this, the challenges of transition, at times, had implications for patient safety. It was observing these experiences that triggered my desire to explore how we as nurses and educators could better support the IQN transition process. For the last three years, I have worked as an undergraduate nursing tutor in a tertiary institution. My belief is that the IQN social, cultural, and historical context must be unfolded and explored in order to identify similarities and differences in approaches to nursing. This would provide a platform to enable understanding and support for IQNs through education and in clinical practice. This study affords an opportunity for this exploratory research.

## **Terms used in this study**

### ***IQNs***

There is a range of titles for internationally qualified nurses in the literature such as internationally educated nurses (IENs), overseas educated nurses (OENs), internationally registered nurses (IRNs) and immigrant nurses, to name a few. This study chose IQNs as it is the term adopted by the NCNZ.

### ***Patient safety***

In healthcare literature there are multiple definitions for patient safety (Runciman et al., 2009). An international classification for patient safety (ICPS) drafting group, working for the World Health Organisation (WHO), defined the key concepts of patient safety. For the purpose of this study I have used the ICPS definition of patient safety: “The reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum” (Runciman et al., 2009, p. 21). Although this is not the specific focus of this study, cultural safety is an integral part of patient safety and therefore I have included the NCNZ definition of cultural safety, as an addition to the ICPS definition. The IQNs are introduced to this concept during the CAP course. It is defined by the NCNZ (2016) as:

The effective nursing practice of a person or family/whanau from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation, gender, sexual orientation, occupation and socioeconomic status, ethnic origin or migrant experience, religious or spiritual belief, and disability. (p. 32)

The NCNZ (2016) state that the nurse must be able to undertake a “process of reflection on their own cultural identity”, understanding that this has an impact on their professional practice (p. 32).

### ***Competence and NCNZ competencies***

In NZ, The Health Practitioners Competency Assurance Act (2003) states that:

The principal purpose of this act is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practice their professions. (p. 13)

This Act ensures health practitioners are competent to maintain patient safety or, in terms that relate to the ICPS definition, minimise risk to the patient.

The fitness-to-practice competencies for registered nurses were developed by the NCNZ in response to this Act, and state the purpose on the cover page, as: “Regulating nursing practice to protect public safety” (NCNZ, 2016). Competence is defined as “the combination of skills, knowledge, attitudes, values, and abilities that underpin effective performance as a nurse” (NCNZ, 2016, p. 32). This definition of competence is comparable to Australia’s, the United States’ and Canada’s Nursing Council definitions (Vernon, Chiarella, & Papps, 2011). The NCNZ sets out four domains of competence in which the competencies are organised. This study used these competencies that constitute safe nursing practice in NZ as the basis for analysing the IQN participants’ perceptions of the competencies that pertain to patient safety. This study appreciated that the concept of competencies used in the regulation of nursing practice in NZ may differ from that in the participants’ country of origin. Therefore, in this study, participants were asked in the interviews to describe what sort of values, attributes and skills they attributed to safe nursing practice. They were also asked for specific situations where they had to act to ensure patient safety in order to explore their perceptions of the competencies that pertain to patient safety.

### ***Preceptorship***

The NZ nurse educators preceptorship subgroup (2010) defines a preceptor as “A nurse who has undertaken a formal preceptor training programme, who assists a beginning practitioner or a nurse changing areas to achieve a competent level of practice” (Appendix III). The NCNZ provide guidelines for competency assessment and state that preceptors are required to complete a formal preceptor training programme and have more than three years’ nursing experience (NCNZ, 2011). For the purpose of this study, the term preceptor will be used to represent the role of registered nurses who role model practice to newcomers.

## **The background context**

### ***The process for IQN registration in NZ, Australia, Canada and the United Kingdom***

Registration in NZ is at the NCNZ’s discretion, as the professional regulatory body. Australian nurses come under the Trans-Tasman Mutual Recognition Act of 1997, and have automatic registration. All other IQNs must apply to the NCNZ, and will have achieved the International English Language Testing System (IELTS) Level 7,

and have evidence of a Registered Nurse qualification or equivalent, as approved by the NCNZ. They must also have worked in the registered nurse role for at least two years post-graduation, and within five years of the application (New Zealand Gazette, 2015). The NCNZ then decides whether the applicant needs to complete a (CAP) course in order to demonstrate their ability to meet NCNZ competencies for registration in NZ. There are currently 20 NCNZ approved courses available for IQNs in NZ (NCNZ, 2017). This type of introduction, training and assessment programme is seen in varying forms in the UK, Canada, and Australia (Xu & He, 2012).

### ***IQN programme content***

In NZ CAP courses, IQNs are required to demonstrate competence in order to gain entry to the NZ nurses' register. The NCNZ competencies sit within four domains of competence. These are: Domain one, professional responsibility which contains competencies that relate to professional, legal and ethical responsibilities and cultural safety; Domain two which is management of nursing care, and which encompasses assessment and management of the health consumers' care; Domain three, interpersonal relationships which considers the therapeutic relationship with the health consumer and the healthcare team; and Domain four which is interprofessional health care and quality improvement and is about working reflectively within the multidisciplinary team, while being able to promote a nursing perspective (NCNZ, 2016). Nurses in NZ must demonstrate meeting these competencies, firstly to gain registration, and then annually to maintain registration.

The CAP course participants were undertaking in this research had a two week campus-based theoretical component at the beginning of a seven week programme. Every session in those two weeks addressed content related to clearly stated competencies. For instance, the Te Tiriti o Waitangi sessions covered competencies 1.2, 1.5 and 3.2. These refer to demonstrating the ability to apply the principles of the Treaty of Waitangi/Te Tiriti o Waitangi to nursing practice, nursing in a culturally safe manner, and practising nursing in partnership with the health consumer (NCNZ, 2016). After two weeks, the IQNs undertake five weeks' clinical placement where they put these competencies into practice. The nurses also completed a combination of assignments, tests, and practical assessment of skills and returned for a theory day in the middle of this placement to revise these

competencies and reflect on their practical application. The NCNZ competencies are assessed over the seven week course, which combines theory and practice.

Although there are variations in time, approach and content of training programmes in Australia, the United Kingdom and Canada, they are all, like NZ, regulated and shaped by their relevant regulatory bodies. Their assessment processes likewise are competency-based, using a combination of written work and supervised practice in the clinical settings (Xu & He, 2012).

## **The structure of the thesis**

Chapter two is a review of the literature pertaining to CoP theory in healthcare as well as literature that investigates IQN transition. Chapter three provides an overview of the methodological approach of this research. It will also discuss trustworthiness and ethical considerations. Chapter four presents the data from the four cases individually and an analysis of the documents pertaining to the CAP course. Chapter five presents a discussion and cross-case analysis as compared and contrasted with previous studies. CoP theory is used to examine and discuss the significance of the findings. A brief overview summarising the main findings from this study is provided in the conclusion chapter. Limitations are discussed. The usefulness of this research is elaborated on and the implications and recommendation for further research in this area.

In the next chapter, research that investigates the IQNs' transition will be reviewed. This will be preceded by a consideration of the use of relevant CoP literature in healthcare.

## **Chapter Two: Literature Review**

### **Introduction**

In this chapter, CoP theory with relevant terms is defined, followed by a review of research that uses this framework in healthcare. The next section will discuss existing research with IQNs. Finally, the gap that the research fills will be identified.

### **CoP as a theoretical framework**

#### **A definition of CoP**

The concept CoP was first introduced by Jean Lave and Etienne Wenger (1991). This situated learning theory proposes that learning is a social process, arising out of a cultural and historical context and located in the dual relationship of a person and their social world. A CoP is a group of people brought together formally or informally for a common purpose. The defining characteristics of a CoP are mutual engagement, joint enterprise, and shared repertoire (Wenger, 1998). Mutual engagement reflects the relationships of the community that produces a sense of giving and receiving and building of trust. Joint enterprise refers to the process of working together to fulfil the objectives of a particular community and, in doing so, learning occurs. Shared repertoire incorporates the routines, tools, language and artefacts associated with this community (Wenger, 2000).

The CoP members are holders of tacit knowledge that is not captured in the formal systems and therefore the CoP is a way of initiating new members into practice and enabling transfer of that knowledge (Wenger, 1998). In the context of this study, IQNs have membership of multiple CoPs. They are members of their own individual family CoP, of their society/culture and finally, their own nursing and healthcare system. They are seeking to enter the NZ workforce through the NZ nursing and healthcare regulatory bodies with the goal of acquiring NZ nursing registration. They will initially be a member of a clinical CoP during their clinical placement on the CAP course, and then upon successful registration, seek to become employed members of a clinical CoP.

Legitimate peripheral participation describes the position of novices and their movement along a continuum to experts. The learning that occurs or mastery of the skills required within a particular CoP enables newcomers to move from legitimate

peripheral participation toward full participation (Lave & Wenger, 1991). To facilitate this movement a more experienced member role models the culture and ethos of the community to the newcomer (Morley, 2016). This concept relates well to Patricia Benner's (1982) seminal work in nursing, which provides a framework for the learning and professional development of nurses. Benner is cited in many of the studies that will be discussed in this literature review relating to CoP theory use in healthcare. In the profession of nursing, the terms preceptor, mentor and supervisor are widely used to describe the role modelling described in CoP theory (Smedley, Nursing, & Morey, 2010). In this study the term preceptor will be used.

Another key concept in the CoP theory is identity. As a new member of a CoP participates in the social learning system of the community a transformative process of identity formation within that community, takes place (Farnsworth, Kleanthous, & Wenger-Trayner, 2016). Professional identity formation is also a recognised concept in nursing (Benner, Stutphen, & Leonard, 2010). For this study, in the CoP context, identity refers to the newcomers' changes in practice to develop competence as defined by the CoP (Wenger, 2000) as they assimilate new ideas and are immersed in the new environment. It is this transformative process of identity formation that is used in this study to describe IQN transition into the NZ nursing context. Evidence of IQN transition will therefore be measured by the IQNs' own perceptions of competence as they understand the NCNZ nursing competencies. Although identity formation/transition is not the primary focus of the research, it is addressed in the Cross-Case Analysis and Discussion chapter.

Finally, the concept of boundaries is integral to CoPs. CoPs are defined by a social history of learning and therefore create boundaries for those who have participated in this learning and those who have not. The community, therefore, defines competence within their area of practice and the boundary determines who may participate (Farnsworth et al., 2016).

### **The use of the CoP theory in this study**

Using CoP theory allows for acknowledgement that the IQN's perception of priorities in nursing are constructed in the social, cultural, and historical context of healthcare in their country of origin. "Communities of practice develop around things that matter to people. As a result, their practices reflect the members' own



understanding of what is important” (Wenger, 1998, p. 2). This exploratory research is designed to examine IQN perceptions of the competencies that pertain to safety or safe nursing practice. With the CoP lens, the findings of this study will be examined and implications for ongoing educational structure and support will be discussed.

### **The use of CoP in health research**

The use of CoP in healthcare is relatively recent, emerging in literature in the late 1990s and early 2000s (Berry, 2011; Woods, Cashin, & Stockhausen, 2016; Li, et al., 2009). This section focuses on the ways CoP theory has been used in healthcare literature. The databases used for this review were Proquest central, Cinahl complete, A+ Education, ERIC, Education Source, Scopus and Science. Search terms were “Communities of Practice”, “nursing” and “nurs\*”. Inclusion criteria were 2006-2016 and scholarly journals. The literature was examined and a representation of the main body of themes was selected for discussion. The three overarching themes that emerged were: Legitimate peripheral participation; online collaboration, support and knowledge sharing; and transition across borders/boundaries. These themes each represent a particular aspect of CoP theory, although it is acknowledged they are interrelated. Furthermore, identity formation (transition) of the newcomer to a CoP is such an integral part of CoP theory that it is interwoven through the three themes.

### **Legitimate peripheral participation**

Increasingly, research using CoP theory as the framework, is being used to help develop optimal learning environments for healthcare students or newly qualified nurses (Li et al., 2009). These studies also investigate factors that support or inhibit the learning process in a CoP. This encompasses the concept of legitimate peripheral participation in which a newcomer learns through a social process of co-participation in the activities of a CoP alongside more experienced members (Davis, 2006). This section discusses these studies and is broken into subheadings that focus on specific components of legitimate peripheral participation.

### ***Relationship: Acceptance, respect and collaboration***

This subheading relates to the premise of mutual engagement, which is seen as one of the three key components of a CoP. The way in which individuals engage with one another within a CoP has a profound effect on shaping their identity within that community (Wenger, 2000). As healthcare literature in this section explored this premise, it highlighted that the relationship students and novice practitioners had with both staff and their own peers in clinical practice had an enhancing or inhibitory effect on their learning.

An American study involving 25 second and third year nursing students participating in focus groups discussed learning in the clinical environment (Ranse & Grealish, 2007). The experience of being welcomed and feeling accepted as a member of the clinical team was seen as very important to the students and was perceived to enhance their learning experience. Similarly, Davis (2006) found that clinical environments that encouraged mutual engagement within their own clinical team and with students enhanced development of a strong professional identity. In a Swedish study as student nurses, occupational health and social work students worked together to manage patient care, they found that interprofessional, collaborative practice added value to their learning (Lidskog, Löfmark, & Ahlström, 2009).

Examining the culture of a clinical environment, an ethnographic study in Sweden revealed how interactions between medical and nursing students and staff members affected learning (Hägg-Martinell, Hult, Henriksson, & Kiessling, 2015). The study found that the workplace culture influenced students' ability to adapt to the CoP and to interact with its members, thus, affecting students' ability to learn. For instance, the busyness of the ward and the workload of the staff affected the quality of student preceptorship by creating a barrier to staff interaction and communication, preventing the sharing of tacit knowledge with the student.

This sharing of tacit knowledge in the CoP is considered an important factor in contributing to learning (Wenger, 1998). In an attempt to explore how knowledge was acquired in a healthcare CoP, case study methodology was used in an Australian outpatient department in a public hospital (Perrott, 2013). The clinic was viewed as a subunit CoP within the organisational CoP. The clinic itself was for spinal cord injury patients who had pressure injuries, providing access to a

multidisciplinary team. This included doctors, nurses, social workers, physiotherapists and occupational therapists. The author describes the key finding of this study which was that the transfer of tacit to explicit knowledge was happening in the corridor, encouraged by a culture of trust in the clinic CoP.

The quality of the relationships among experts and novices in a CoP was also investigated by Portoghesi et al. (2014). This study investigated what made students feel respected in the clinical placement settings during their training, which was considered important as there seemed to be a significant link between students feeling respected and motivation to engage in a CoP. A survey of 188 year two and three nursing students revealed students perceived that receiving feedback (interaction, reflection and discussion) was viewed as an important part of respect. Clarity about their role within the clinical environment also impacted the students' perceptions of respect. Lidskog et al. (2009) found clarity of role and explicit learning goals for students were likewise highlighted by students in their study as conducive to learning.

Thrysoe, Hounsgaard, Dohn, and Wagner (2012) explored participation in a CoP of newly qualified nurses (NQNs) as they interacted with members of their professional community. Professional interaction with colleagues appeared to have an influence on NQNs' participation over time. Participation was facilitated by professional dialogue that included NQNs. Social interaction with the members of the CoP encouraged a feeling of equality with the NQNs and also promoted participation. Minimal interaction with the NQNs made them feel isolated and unable to move on an inward trajectory towards full participation in the CoP. This study highlighted that there are conditions that can enhance or deter the transition from legitimate peripheral participation to full participation within a nursing CoP.

### ***The role of the preceptor***

The role of the preceptor is discussed in the section above regarding relationships; however, it seemed important to also discuss it separately as literature highlights the importance of this specific relationship within the CoP. In an ideal preceptor/preceptee relationship the more experienced member will embody the history and ethos of a CoP and the more time spent with the preceptor enables the preceptee to make meaning of the many aspects of the nurse's role (Morley, 2016). Hägg-Martinell et al. (2015) noted that when key experienced members of staff

were present in the clinical area, they were able to support students and novice colleagues as they role modelled the culture and ethos of the ward. Davis (2006) suggested that the role of the preceptor is fundamental in enhancing student learning. Findings from her multiple case study involving five occupational health student participants revealed that preceptors that used a permissive style of preceptorship were preferred. This style was described as encouraging active participation in patient care and open discussion of learning ideas and needs with the students. The participants believed this style of preceptorship was more effective for learning and identity development as opposed to preceptors that used a more directive style that did not encourage such active participation, either with patient care or inclusive discussions with staff. This view was echoed by nursing students in Ranse and Grealish (2007) and Grealish and Ranse (2009). Furthermore, preceptors who role modelled what students perceived to be good nursing practice also enhanced student learning, as opposed to preceptors that were not perceived to be confident or competent in their nursing practice (Grealish & Ranse, 2009).

In a study that explored the preceptors' perceptions of what was conducive to learning in a CoP, quality of relationship was the most prominent theme that emerged (Sayer, 2014). The preceptor participants perceived that mutual engagement, acceptance, trust and respect between preceptors and preceptees, as well as other members of staff was vital to learning. Conversely, poor relationships involving power and conflict issues were perceived as inhibitory to learning. Hägg-Martinell et al. (2015) found that the level of support that a student received in a CoP was directly related to the relationship with the preceptor. In this relationship, preceptors had the power to allow students to participate in patient care or be restricted to just being observers.

### ***Active participation***

Central to CoP theory is that through active participation in practice, knowledge and understanding of that practice is developed (Wenger, 1998). This encompasses the concept of joint enterprise, another of the three components of a successful CoP (Wenger, 2000). Andrew, Tolson, and Ferguson (2008) describe it in terms of "belonging, participation and collaboration" (p. 247). The joint enterprise arises out of mutual engagement with members of the CoP, which highlights the importance of these relationships and how the two are interrelated (Hägg-Martinell et al.,

2015). Wenger (1998) states that joint enterprise can only happen when mutual engagement is successful.

Active participation of nursing students in clinical practice allows them to access tacit knowledge as they interact and participate in patient care (Berry, 2011). Ranse and Grealish (2007) sought to understand the student experience of learning while participating in a CoP. Findings showed that active participation in patient care was perceived by the 25 student nurse participants as fundamental in the transfer of learning from the classroom context to the clinical environment. In a later study, 62 student nurses believed that participating in patient care enabled them to begin to understand the complexity of the nursing role (Grealish & Ranse, 2009). Challenging situations involving patient care that triggered strong emotions, both positive and negative, were also perceived by students as powerful learning opportunities (Grealish & Ranse, 2009).

With this same assumption, an American university, believing leadership to be a key nursing skill, required nursing students as part of their curriculum to actively participate in leadership projects in practice settings (Ailey, Lamb, Friese, & Christopher, 2015). The participation was found to have a positive impact on the students' learning. Similarly, Lidskog et al. (2009) found that the students who actively sought to participate in learning opportunities involving patient care learned more rapidly than those who did not.

### ***Reflection upon practice***

Reflective practice is foundational to the CoP situated learning perspective, and this reflective practice occurs as members of the CoP interact and communicate in everyday practice. This is where the tacit knowledge becomes explicit (Lave & Wenger, 1991). Students in a CoP are able to apply their classroom learning through practice and test its effectiveness through their experience and reflection with peers and members of the CoP (Davis, 2006). The value of reflection was acknowledged by students in many of the studies in this review. Clinical placements and active participation in patient care, coupled with interaction with staff that involved feedback, was acknowledged as vital to learning (Davis, 2006; Grealish & Ranse, 2007; Hägg-Martinell et al., 2015; Portoghese et al., 2014; Ranse & Grealish, 2009).

### ***Regeneration of CoPs***

Wenger (1998) proposed that the novice in a CoP can have a positive impact in generating new knowledge within the CoP. Morley (2016) describes this process as occurring when new members enter a CoP, they bring fresh ideas and outlooks that allow for new perspectives and challenges to accepted norms. Sayer (2014) found that new members help redefine the identity of a CoP with their own contributions and new knowledge. Newly graduated nurses in Thrysoe et al. (2012) indicated that as the knowledge they had regarding nursing issues was valued by members of the CoP, this became an incentive to increase confidence and lead to increased participation. Nursing students in Ranse and Grealish's (2007) study believed that they contributed new knowledge and fresh perspective in their clinical placement.

### ***Collaboration between professionals***

Literature on CoP has proposed that it is a concept that may be useful as a means to encourage collaboration between academics in nursing education and nurses in practice for the benefit of student nurse learning (Andrew et al., 2008; Berry, 2011; Morley, 2016). Dedication Education Units (DEU) have been developed in an attempt to bring about such collaboration. The (DEU) model originated in Australia and NZ and has begun to be seen in the United States (Morley, 2016). The DEU environment was investigated in the Ranse and Grealish (2007) and Grealish and Ranse (2009), studies that were discussed at several points in this section. Both these studies revealed that the DEU concept appeared to facilitate and enhance student learning.

### ***Limitations of CoP***

Wenger (1998) spoke of potential issues in CoP. One such issue was that the strength of relationships that can develop within a CoP can create barriers for newcomers. His vision was that newcomers would bring fresh ideas and new knowledge that would challenge stagnated practice and accepted norms. However, he cautioned that this may not happen. Citing this potential limitation, Sayer (2014) discussed critics of CoP theory who believed the concept of legitimate peripheral participation was too simplistic and alluded to the newcomer being on an incoming trajectory of participation that only allowed the newcomer to absorb the ways of

that community and not vice versa. However, in many of the studies discussed earlier, a sense of reciprocal learning was noted.

Wenger (1998) believes motivation to learn is inherent in the new member as they enter a CoP. Kupferberg (2004) proposed that this view is too simplistic and motivation to learn in an individual is a far more complex issue. Although motivation to learn was not the focus of this review, findings would support that overall motivation to learn was apparent in the students and new staff represented in these studies. However, several studies highlighted that some students showed more motivation than others to actively seek learning opportunities. Motivation was also found to be affected by factors such as acceptance, perceived value and respect, and opportunity.

In summary, the literature on the concept of legitimate peripheral participation within the health care profession supported the suitability of using CoP theory to analyse and enhance learning. The relationships and collective nature of CoP are what make them effective learning environments (Berry, 2011). When the elements of mutual engagement, joint enterprise, and shared repertoire combine successfully, then knowledge is created and exchanged (Li et al., 2009). However, the workplace conditions, and the relationships between the staff members and students or new nurses were found to promote or hinder student learning. This appeared to signify that the effectiveness of learning is dependent on the commitment of the CoP members to learning and the generation of new knowledge. Thrysoe and colleagues (2012) stated the importance of investigating clinical environments in the attempt to create the elements necessary to promote learning and legitimate peripheral participation.

### **Online collaboration, support and knowledge sharing**

This section shares a focus on CoP being used in the literature as a model for online collaboration, support and knowledge sharing, particularly as a means of bridging geographical separation (Woods et al., 2016).

Interprofessional collaboration and learning were examined in an online CoP amongst nursing, radiotherapy and radiography students (Moule, 2006). The group displayed the concepts of mutual engagement, joint enterprise, and shared repertoire over an eight-week period to differing degrees. However, a lack of face-

to-face interaction limited mutual engagement and some participants thought that eight weeks was too short a time period to fully develop a shared repertoire. Despite this, some valuable learning occurred and the authors concluded that an online CoP was a useful tool for learning.

In Singapore, case study research investigated an established online CoP for health practitioners and administrators to examine the types of activities undertaken, the types of knowledge shared, and what sustains such communities (Hara & Hew, 2007). The data were analysed using CoP theory, focusing particularly on the aspects of knowledge sharing and identity formation. In this online CoP, knowledge sharing in the form of personal opinion and institutional practice, and the solicitation of answers to practice issues occurred. Validation of practice and knowledge sharing as a means of producing best practice was found to be the primary outcome of this online CoP.

Similar findings emerged from a Canadian study that evaluated an online CoP that was established to create a support network for community health nurses working with homeless patients who often reported feelings of isolation and stress (Valaitis, Akhtar-Danesh, Brooks, Binks, & Semogas, 2011). Findings supported that, overall the nurses viewed this CoP as a place to share stories, validate practice, and adapt best practices to their work context.

### **Transition across borders/boundaries**

The last of the three themes represents literature that explored issues related to professionals who are attempting to make a transition between two CoPs.

Using CoP theory, the transition process of practice nurses to lecturers in higher education was examined in the UK (Boyd & Lawley, 2009). Findings highlighted a struggle for participants between holding on to their former identity as practising nurses and transitioning to a new identity as academics. Concluding remarks suggested additional support for new nurse lecturers to encourage a more critical stance toward this new identity formation. In an attempt to address this same issue, a model informed by CoP theory was proposed in Australia to support practice nurses into educator roles (McAllister, Opreescu, & Jones, 2014).

In Canada, the underutilisation of IQNs inspired a case study involving IQN Prior Learning Assessment and Recognition (PLAR) candidates, assessors, advisors,



managers and directors to explore how quality in the PLAR process could be understood. The PLAR process itself refers to a process that attempts to equate prior learning and credentials with the standards required in Canada for fitness to practise (Van Kleef & Werquin, 2012). This could be equated with the process the NCNZ undergoes when assessing an IQN application for registration in NZ. Lave and Wenger's (1991) CoP theory, combined with the concept of consequential transition developed by Beach (2003), were used to provide a conceptual framework for the research (Van Kleef & Werquin, 2012). Consequential transition theory centres on the premise that learning occurs and is consequential when the learner is engaged in the process and consciously reflects upon situations. This process can result in changes in perspective of themselves and their social positioning (Beach, 2003). There were 18 IQN participants, 15 female and three male, only one of which spoke English as a first language. Two semi-structured interviews were used for data collection. At the time of the study, all participants were working in the healthcare industry in Canada, requiring competencies at a lower level than nursing. Inductive thematic analysis was used with emerging themes, exposing differences between nursing education and nursing practice from their own countries. The differences were in their education processes, culture, scope of practice, and relationships within the health environment, technology and terminology. The PLAR process and lack of collaboration with them engendered anger, frustration, and disappointment amongst the participants. They collectively echoed the idea that when gaps in their competency were identified there should be approved courses to fill the gaps rather than directing them to complete a three-year undergraduate degree.

Through the lens of CoP theory and consequential transition the authors described new learning and transition as a process of reshaping and enlarging previous learning. According to Van Kleef and Werquin (2012), this is more likely to occur within social practices that are involved in assisting this process and posed the question of what the nursing profession can do to assist with this transition. Conclusions were drawn that nurses who are educated outside of Canada stand on the periphery of the nursing community without a voice despite being key stakeholders in the PLAR process. Further studies regarding the IQN voice in this process were recommended.

## **Summary: CoP theory and healthcare**

The three themes that emerged from this review highlight the potential for using the CoP framework to enhance and explore learning and the transition process in nursing, whether it is as a student entering the profession, a new graduate, a nurse entering teaching, or an IQN entering the NZ healthcare system. CoP is also suggested as a means to bridge the gap between nursing education and nursing practice to enhance student experience (Berry, 2011), and to challenge and create new knowledge in nursing (Andrew et al., 2008). Finally, CoP theory is suggested as a framework for developing online CoP for collaboration, support and knowledge sharing, particularly for those geographically separated. At the centre of this research project is patient safety as articulated in the introductory chapter. Specifically in the case of IQN transition, CoP theory provides a useful framework with which to examine how the concept of patient safety is shaped both in the IQNs' country of origin and during the process of a CAP course.

## **IQNs**

Current research concerning IQN transition is focused on developing and ensuring processes and programmes provide adequate training and support to ensure patient safety (Peisachovich, 2015). Many of the nurses who apply to work in new countries have extensive knowledge and experience in their country of origin and their safety to practise within that environment is not in question (Peisachovich, 2015). Despite this, it is recognised that transition into an entirely new culture and health system presents challenges that can compromise patient safety (Xu & He, 2012).

Three prominent themes emerged from the review of current literature. Patient safety was at the heart of all three. These themes were broadly classified as communication barriers, cultural differences, and IQN preparedness for practice. In recognition of the fact that communication and cultural difference are inextricably intertwined, these two themes are discussed in the same section.

### ***Communication barriers/cultural difference***

Effective communication is recognised as a key factor in patient safety (Xu & He, 2012; Xu, Shen, Bolstad, Covelli, & Torpey, 2010; Xu, Staples, & Shen, 2012). Furthermore, issues with communication have been identified as the root cause for most sentinel events in healthcare (Shen et al., 2012). Communication can be

defined as “a reciprocal process between at least two people of sending a message and interpreting it correctly through both verbal and nonverbal means” (Xu et al., 2012, p. 292). Communication issues were identified as one of the primary factors contributing to the challenges facing IQNs by employers, regulators, and the IQNs themselves (Adeniran et al., 2009; Shen et al., 2012; Xu et al., 2010; Xu et al., 2012; Wagner, Brush, Engberg, Nicholas, & Capezuti, 2015; Zizzo & Xu, 2009). The first item addressed in IQNs’ communication is an ability to speak and understand the language of the country they are entering, in the case of this research, English.

The IELTS and the Occupational English Test (OET) are both used by the countries mentioned in this study as part of the criteria for nursing registration. However, Xu et al (2010) and Xu et al (2012) argue that the IELTS test is not necessarily a good indicator of work place communication competency. Similarly, Muller (2014) stated that IELTS is designed to assess the candidates’ preparedness to start university studies and the OET only measures English language proficiency and not clinical competence. Muller contended that IQNs need ongoing education post the IELTS process to ensure competency in communication in the health sector. This indicates that the education and health agencies working with IQNs need to understand the limitations of the IELTS and OET.

A quasi-experimental designed, two-part pilot study in the United States focused on improving the communication skills of IQNs (Shen et al., 2012; Xu et al., 2010). The first pilot study provided a ten-week course on reducing phonologic errors in IQNs to improve communication which resulted in a significant reduction in these errors (Shen et al., 2012). Part two of this pilot study provided workshops on sociocultural communication skills in the belief that communication cannot be separated from culture and context (Xu et al., 2010). The sociocultural competency of the participants was evaluated prior and post the intervention by standardised patients. These were actors or laypersons trained in enacting scenarios in a consistent manner. No significant improvement was noted after the intervention. This was attributed primarily to the mean length of time the participants were in the United States, with the longest being 13.8 years, indicating their sociocultural skills were already of a high standard. One of the four workshops offered in this study recognised that the non-verbal and intuitive cues given by the patient

potentially conflicted with IQNs' own cultural practices (Xu et al., 2010). This finding was thought to have implications for patient safety.

The two pilot studies laid the foundation for a study investigating non-verbal communication behaviours of IQNs (Xu et al., 2012). Fifty-two participants were assessed in videotaped scenarios by standardised patients on non-verbal behaviours. A qualitative analysis of the two most extreme cases was undertaken. The participant who scored 5/5 on the Likert scale had been in the country for 30 years. The participant who scored 2/5 had been in the country two years. The research concluded that targetted communication training should be provided early in IQNs' orientation so that learning was not through a trial and error process. The second conclusion drawn from the case with the score of 2/5 was the gap in how the IQN perceived him or herself, firmly believing they were compassionate and caring, contrasting with the patients' perception that they seemed cold. This was attributed to the difference in healthcare culture in the United States compared to the IQN's country of origin.

Peisachovich (2015) conducted a study in Canada involving a purposive sample of four IQNs (enrolled in a university bridging programme) in videotaped, simulated clinical activities. This was followed by stimulated recall and focus groups. The purpose of the study was to investigate the IQN's understanding of clinical judgement to support its application in practice. During the course of this study, the IQNs gained added insight into the way their culture influenced their perception and interpretation of information in the clinical setting, and how this could impact patient safety (Peisachovich, 2015). The findings supported the need for more research in the area of IQNs' perceptions and understanding of the culture of nursing in a country very different to their own.

Communication challenges pervaded the literature concerning IQN transition and appeared to call for more research and understanding of this issue than just language proficiency alone. The next most prominent issue was the IQNs' lack of preparedness for practice.

### ***IQNs' preparedness for practice***

Current literature appears to be highlighting the issue of IQNs' lack of preparedness for practice in their new countries (Adeniran et al., 2009; Allan, 2010; Njie-Mokonya & Josephine, 2014; Stankiewicz & O'Connor, 2014; Woodbridge & Bland, 2010; Zizzo

& Xu, 2009). In the United States, a “Transitioning Internationally Educated Nurses for Success” programme was designed in recognition of the growing IQN numbers in the United States and the challenges faced by them (Adeniran et al., 2009). This model provided evidence of the growing recognition that these challenges needed addressing in order to enhance patient safety.

A systematic review of transitional programmes for IQNs was conducted by Zizzo and Xu (2009) to ascertain the availability, content and research basis for the programmes such as those mentioned above. Twenty were identified and investigated. Findings from the review overwhelmingly indicated the lack of empirical evidence to guide the content of the programmes, with the obvious call for more research in this area (Zizzo & Xu, 2009). Researchers investigating bridging programmes in Canada supported this call, stating research in this arena was in its infancy stage (Lum et al., 2011).

IQN's transitioning to practice in Canada believed orientation and professional development opportunities offered to them were inadequate (Njie-mökonya & Josephine, 2014). This qualitative study investigated IQNs' experiences of their orientation and transition process. IQNs acknowledged that they felt they needed a time period of two to three years of transition to be working effectively in Canada. This perception of the orientation and transition process is supported by findings of an American study of Taiwanese IQNs (Ho, 2015). Research involving 31 Filipino IQNs in America highlighted the need for orientation programmes designed specifically for IQNs, emphasising the importance of seeking IQN feedback on this process (Lin, 2014).

In the United Kingdom, a qualitative study involving 93 IQNs investigated their preceptorship experiences in the healthcare sector. This study discovered discrimination and bullying towards IQNs and lack of understanding of their learning needs. The need for specific preceptor training was highlighted as vital to the success of this process (Allan, 2010). Similarly, Okougha and Tilki (2010), in a study involving 13 Ghanaian and Filipino IQNs in the United Kingdom recommended that the emphasis placed on the IQNs' understanding of their new culture in the transition process must be reciprocated by a workplace emphasis and understanding of IQN culture. They believed this would provide better support for the transition process. This implies that not only do transition programmes play a

role in preparing IQNs for practice but that the institutions that employ them have responsibilities to acknowledge the challenges of transition and work towards supporting it (Stankiewicz & O' Connor, 2014; Woodbridge & Bland, 2010).

Current health literature also supports the need for institutional responsibility for preceptor support and training in general (Haggerty, Holloway, & Wilson, 2012; Kalischuk & Awosoga, 2013; Smedley, Nursing, & Morey, 2010; Staykova, Huson, & Pennington, 2013). The NZ Nurse Educators' group (2010) developed a framework for nursing preceptorship programmes. Within this framework, the additional challenge for preceptors in relation to understanding and meeting individual IQN learning needs was recognised. Despite this, there is no additional training developed. A quantitative study involving 151 self-identified (for IQN with English as a second language) preceptors in NZ found that 23% of these preceptors did not meet the NCNZ standards for preceptorship (Riden, Jacobs, & Marshall, 2014). Furthermore, many of them felt unsupported in training, time to provide effective preceptoring (with full workloads), and recognition of the role. Recommendations from this study were for specific training for IQN preceptoring within the national framework and better organisational support and recognition. An organisational and national preceptor register that would encourage quality assurance was also recommended (Riden et al., 2014).

These studies highlight the issue of educational preparation and clinical support for IQNs as appearing to be inadequate both in NZ and internationally.

## **The need for my study**

This literature review has shown that increasingly CoP theory is being used in healthcare as a framework for investigating how learning and transition happen. Equally, growing numbers of studies are emerging in an attempt to address safety issues involved in IQN transition. However, only one research project was found that used CoP theory as a framework to investigate IQN transition drawing on the IQNs' perspectives. Very useful and important issues were highlighted in this study (Van Kleef & Werquin, 2012). My research proposes to add to the limited body of research that attempts to explore IQN perspectives through the lens of CoP theory. Research in this area will inform the recognition and provision of ongoing education and support in the health care workplaces as well as CAP programmes.

## **Chapter Three: Methodology**

### **Introduction**

This chapter will outline the methodological approach taken and justify why this was the most appropriate design to answer the research questions. It will also describe the data collection and analysis process. Finally, there will be explanations as to how this research maintains trustworthiness and ethical considerations.

Migration of nurses is a growing international phenomenon (Yeates, 2010). The challenges of transition faced by IQNs are highlighted in literature (Xu & He, 2012). Despite many of the IQNs having extensive nursing experience in their country of origin (Peisachovich, 2015), it has been found that these challenges can have implications for patient safety (Xu & He, 2012). This study was designed to investigate this complex phenomenon by exploring IQN perceptions of the competencies that pertain to patient safety. A secondary focus was to consider if exposure to the NCNZ competencies in the theoretical component of the CAP course and in clinical placements had any impact on these perceptions.

### **Research questions**

#### **Primary research question**

How do IQNs report their perceptions of nursing competencies that relate to patient safety?

#### **Sub questions**

- How do IQNs report perceptions of competencies that pertain to patient safety at the beginning of a Competency Assessment Programme (CAP)?
- How do IQNs report perceptions that pertain to patient safety at the end of a CAP?
- How are these competencies articulated in documents relating to the CAP?

#### **Research paradigm**

A research paradigm is “a perspective held by a community of researchers that is based on a set of shared assumptions, concepts, values and practices” (Johnson &

Christensen, 2012, p. 31). The qualitative researcher's key concern is to understand a phenomenon of interest from an emic perspective (Merriam, 2009). Therefore, qualitative researchers believe it is important to get as close to the focus of the research as possible in order to understand, interpret, and represent their perspective as accurately as possible (Johnson & Christensen, 2012).

Qualitative research assumes an interpretive-constructivist approach.

Creswell (2007) describes this as:

In this worldview, individuals seek understanding of the world in which they live and work. They develop subjective meanings of their experiences....These meanings are varied and multiple, leading the researcher to look for the complexity of views....Often these subjective meanings are negotiated socially and historically. In other words, they are not simply imprinted on individuals but are formed through interaction with others (hence social constructivism) and through historical and cultural norms that operate in individuals' lives. (pp. 20-21)

It is characterised by an inductive process from which typically themes or possible hypotheses emerge from the data (Merriam, 2009). Rich description in words and images is essential rather than in numbers as is the case in quantitative research (Merriam, 2009).

In this study, the phenomenon of interest is the perception of patient safety within the transition of IQNs to new professional contexts. A qualitative research paradigm allows multiple views of patient safety from the IQN perspective, and the social constructivist focus aligns with the conceptual framework of this study.

## **Research design**

This research uses a qualitative case study design. This requires an in-depth analysis of a case or cases within a defined context (Creswell, Hanson, Clark Plano, & Morales, 2007). Regardless of the topic area being investigated, the rationale for the choice of case study is the desire to investigate complex social phenomena (Yin, 2014). The choice of case study relates to the researcher's belief that the contextual conditions of the case are highly relevant to the phenomenon under investigation and impossible to separate (Yin, 2014). In this study, the CoP conceptual framework allows the social, cultural, and historical context of the IQNs to be revealed within the data. Finally, Yin (2014) refers to "how" and "why" research questions as exploratory in nature and appropriate for case study design.



Merriam (2009) defines case study as “an in-depth description and analysis of a bounded system” (p. 40). This boundary is the equivalent of what Creswell et al (2007) refers to as defined context. Merriam (2009) describes this as a means to “fence in” what is to be studied (p. 40). Multiple-case design was selected as opposed to single case design in order to enhance the potential robustness and transferability of the findings (Merriam, 2009; Yin, 2014), and to provide different perspectives on the phenomenon of interest (Creswell, 2007). In multiple case design there remains one issue that is under investigation, but it uses more than one case to illustrate the issue (Creswell et al., 2007). The cases in this research are the individual IQNs with the defined context or boundary being the period of time the IQNs attended the CAP course.

## **Theoretical framework**

A theoretical framework is the foundation or frame of the study, bringing with it an orientation or stance for the research (Merriam, 2009). Wenger’s (1991) CoP theory was used in this study as it is a social learning theory that locates the experience of meaning-making between an individual and their social world (Farnsworth et al., 2016). According to Wenger (1998) this meaning-making is embedded in a social, cultural, and historical context. This is integral to the investigation of this research. The purpose is to discover IQN understanding of the core nursing concepts concerning patient safety as constructed in their social, cultural, and historical context. CoP theory also theorises how learning happens across boundaries in a new CoP or context. As the IQNs enter the new environment of nursing in NZ during the CAP course, the key concepts of learning and transition in CoP theory will be analysed.

## **Participants**

Purposive sampling within a CAP course was the method used. The inclusion criteria were as follows;

- English as an additional language
- Living in NZ five years or fewer
- Participant in the CAP course.

The CAP course commenced Monday, May the 9<sup>th</sup> 2016 when the participants attended a two-week theoretical component. They then spent five weeks working in clinical placements. In the middle of these five weeks, on June the 8<sup>th</sup> they returned for one day of class to reflect on clinical placement and review NCNZ competencies as enacted in the clinical setting. There were 18 participants on this course, 13 of whom met the criteria for this study.

An adequate number of participants relates to factors such as the questions being asked, and the amount of data that will allow reasonable coverage of the research issue (Merriam, 2009). According to Creswell et al (2007), an ideal number in case study research is four to five participants to provide enough data to make comparisons. To recruit the IQN participants, I first contacted the class that was to be undertaking the CAP course by email, one week prior to the course. I outlined the study and my intention to come to class within the first two days of their programme (See appendix A). The purpose was to prepare them for my visit and give them some time to think about the study prior to meeting me. From this email, I received several responses indicating a desire to be part of the research. When I visited the class, I gave the class members an information sheet and consent form (See Appendices B and C) and invited them to take part in the study. I discussed the study and allowed time for questions. This occurred on the first day of the CAP course. On that day, one IQN volunteered to participate in the research. Over the course of the next week three more participants volunteered (via email correspondence), through snowball sampling in which research participants are asked to identify further potential research participants (Johnson & Christensen, 2012).

## **Data collection**

A unique strength of case study design, strengthening construct validity, is the use of more than one source of data (Yin, 2014). This enables several measures of the same phenomenon. In this study, data sources were participant interviews, participant email reflections, and CAP course documents.

According to Yin (2014), "One of the most important sources of case study evidence is the interview" (p. 110). Interviews were the primary source of data gathered in this study. I interviewed the four IQN participants twice using a semi-

structured format. This form of interview allowed for flexibility and fluidity of process (Yin, 2014). Some structure is appropriate for guiding the questions and obtaining information such as demographic data (Merriam, 2009). The interview questions are included in Appendix D. The interview schedule is reflected in Table 1. The interviews were conducted as close as possible to the beginning and end of the CAP course, while the participants were on campus (for their convenience), and in an appropriate room away from their classroom. The interview times were at the convenience of the participants. The interviews were audio recorded.

**Table 1. Participant interview schedule**

Dates	Interview 1	Interview 2
Participant 1	10 <sup>th</sup> May 2016	8 <sup>th</sup> June 2016
Participant 2	17 <sup>th</sup> May 2016	8 <sup>th</sup> June 2016
Participant 3	18 <sup>th</sup> May 2016	8 <sup>th</sup> June 2016
Participant 4	18 <sup>th</sup> May 2016	8 <sup>th</sup> June 2016

Email reflections were the second source of data for this study. I emailed the participants at the end of the first week of clinical placement and at the end of clinical placement, and asked for a brief reflection. These prompts were sent in the email, enabling them to reply as briefly as they wished:

1. How is the course going for you?
2. What are the challenges and successes that you have experienced?

Table 2 provides a record of the dates the email reflections were sent and when and if the participants responded.

**Table 2. Email reflection schedule**

First email sent 31 <sup>st</sup> May 2016	Second email sent 27 <sup>th</sup> June 2016
Participant 1 did not respond	Participant 1 responded 27 <sup>th</sup> June
Participant 2 responded 31 <sup>st</sup> May	Participant 2 responded 28 <sup>th</sup> June
Participant 3 did not respond	Participant 3 responded July 1st
Participant 4 responded 31 <sup>st</sup> May	Participant 4 responded 27 <sup>th</sup> June

The final form of data collected were documents pertaining to the CAP course. Merriam (2009) describes documents as useful forms of data for the purpose of verifying emerging findings and providing descriptive information pertaining to the phenomenon of interest. Document analysis helps corroborate and add to findings from other sources (Yin, 2014). A feature of case study design is

a detailed description of the cases that includes the setting and context of the case (Yin, 2014). As questions concerning the competencies pertaining to patient safety were asked during the CAP course, the representation of these competencies in the CAP course was a source of data. A document analysis was undertaken of the CAP course outline, the timetable for the first two weeks on campus, and a lesson plan for the day the students returned to campus during their clinical placement. These three sources of data contributed to triangulation of data, thus further supporting findings.

### **Data analysis**

I transcribed the recorded interviews from the participants, which further enabled an in-depth interaction with the data. A detailed description of each of the IQNs' perceptions around the core issue was provided. "From case study reports pour vignettes and narratives that feed into the naturalistic generalizations of readers and writers" (Merriam, 2009, p. 44). The transcriptions were returned to the participants so that they could check them for accuracy and remove or add anything they wished. They did not request anything to be removed or changed.

Inductive analysis was used in this study. This involved an immersion into the details of the data in order to discover patterns and themes (Johnson & Christensen, 2012). I coded the data from each of the four cases individually using NVivo and then organised the codes into themes. This was an iterative process. The participants' own words were used, where possible, as headings for the emerging themes. The themes were then analysed across the cases in order to aggregate and compare the findings (Yin, 2014). The documents were analysed for competencies pertaining to patient safety, looking for descriptions, assessment criteria, and links to NCNZ requirements.

### **Trustworthiness/credibility**

Trustworthiness in research results is particularly important in applied professions such as nursing because of the close involvement in people's lives, and is achieved if a rigorous process has been followed (Merriam, 2009). To produce credible research Merriam maintains that the researcher must strive to understand the participants' perspective of the phenomenon being studied whilst exposing the

complexity of humanity through the lens of the theoretical framework. This results in a realistic interpretation of the data. As the collector of the data I had extensive experience in the nursing profession, and later in working with IQNs and so was able to have some insight into the participants' perspectives coupled with an understanding of the conceptual framework of the study.

My nursing experience and experiences, however, were also a potential cause of researcher bias. "Rather than trying to eliminate these biases or "subjectivities," it is important to identify them and monitor them as to how they may be shaping the collection and interpretation of data" (Merriam, 2009, p. 15). In order to combat this I practised reflexively by keeping a research journal. This also acted as an audit trail containing my thought processes and the research process itself (Yin, 2014). In addition, I regularly checked data analysis and interpretation of findings with my supervisor, who is not a nurse. Interpretation of findings was also checked with an approved nursing advisor for this research project.

Member checking is seen as potentially the most important way to ensure credibility (Johnson & Christensen, 2012; Merriam, 2009). As a form of member checking I shared the transcripts and emerging findings with the participants for their verification of accuracy of what they said and meant on two occasions after the data collection.

Triangulation of data strengthens the validity of research as there are multiple ways in which the data converge and can be corroborated (Yin, 2014). This research used data from two interviews with each participant, two reflections from each participant, and CAP course documents pertaining to the NCNZ competencies. The convergence of the data is discussed in Chapter five.

### **Generalisability/transferability**

Generalisability is not usually equated with qualitative research because the sample is not usually random and because the documenting is generally particularistic in nature (Johnson & Christensen, 2012). However, Merriam (2009) argues that what we learn from a particular situation can be transferred to other similar situations. The stance taken in this research is that the findings can add to a body of findings that build understanding of learning and transfer of knowledge across cultural boundaries. The provision of rich description so the reader or user of the study can

decide if the findings can be applied to their particular situation enhances transferability (Merriam, 2009).

### **Ethical considerations**

According to Merriam, ethical practice in research guided by policies, guidelines, and codes rely heavily on the individual researchers' own ethical values. The NCNZ code of conduct and ethical behaviour ([www.nursingcouncil.org.nz/Nurses/Code-of-Conduct](http://www.nursingcouncil.org.nz/Nurses/Code-of-Conduct)) is integral to my position as a registered nurse and now as a nursing educator. These same principles have been applied to this research. Ethical permission for this study was granted by the institution where the CAP course was held in conjunction with permission from the chair of the Victoria University of Wellington Human Ethics Committee.

### **Cultural safety**

The concept of cultural safety in professional practice is integral to nursing in NZ. The key focus of this research project was to explore IQNs' perceptions of competencies that pertain to patient safety, believing these to be embedded in their social, cultural, and educational backgrounds. This project did not aim to challenge the cultural identity of the IQNs in any way. The intention and approach were centred on exploring the perceptions IQNs brought with them, in order to highlight similarities and potential differences, as opposed to what was considered lacking. It was also an opportunity to give IQNs a voice in the body of research concerning IQN transition. This view was conveyed and encouraged throughout the interview process.

### **Potential for harm**

Participation in the proposed research did not affect any academic or clinical outcomes for the participants as outlined in the Information and Informed Consent sheets. There was, however, potential for discomfort in sharing perceptions relating to patient safety. This was managed firstly, by reiterating and reassuring them that their sharing in this research had no bearing on their performance in the CAP course, and secondly, by creating a safe and non-judgemental approach to information shared. Referral for further assistance was available if the participants

required it. This information was provided in the informed consent (See appendix B). The interviews proceeded in a relaxed and informal manner and there did not appear to be discomfort of the participants.

### **Informed consent**

Informed consent was obtained following several points of contact described in the section titled data collection. At interview one, the research and interview process was again explained and then the consent form was presented for signing by the participants and me.

### **Confidentiality**

All information was and is kept strictly confidential. The participants were given the opportunity to select pseudonyms for themselves; however, three out of the four participants preferred the name to be selected for them. These names were discussed before the first interview and agreed upon by the participants. There were no visual images used. It is possible that the institution may be recognisable from a description of the context and the participants were made aware of this. I did the transcribing. All hard copies are kept in a locked cabinet and all electronic data are password protected and only accessible by the researcher and her supervisor. This includes recording devices, computer and phone. The data will be destroyed/ deleted after five years. CAP course documents that were used as data in this study were not included in the appendices for confidentiality reasons.

### **Summary**

This chapter has provided a detailed description and justification of the methods and design employed in this study. The method of data collection and analysis was outlined, along with how trustworthiness was obtained. Finally, the ethical considerations were discussed. Chapter four will present the findings of this study.

## **Chapter Four: Findings**

### **Introduction**

Chapter four presents firstly an analysis of the CAP course documents, followed by analysis of the four cases individually, using data from the IQN interviews and email reflections.

### **CAP course document analysis**

As part of the data gathered in this research, three CAP course documents were analysed: The timetable for the first two theory-based weeks, the Course Descriptor, and finally the lesson plan for one day back on campus, half-way through the five-week clinical placement. Together, these documents aim to articulate the NCNZ competencies and illuminate ways in which the IQNs can meet these competencies. Raw data from these documents are not presented so that the institution running the CAP course could not be identified.

The Course Descriptor outlines the aims of the course, the learning outcomes, and the summative assessment requirements. This highlights the purpose of the CAP course for the IQNs and how the curriculum is designed to support them to demonstrate their ability to meet the NCNZ competency requirements. In the 11 learning outcomes (linked to specific NCNZ competencies), the Course Descriptor explicitly mentions both demonstration of cultural safety and client safety within the four domains of competence that together constitute safe nursing practice according to the NCNZ; for example, Learning outcome 2: Practice nursing in a manner that the client determines as being culturally safe (Links to competency 1.5) and, Learning outcome 5: Promote an environment which maximises client safety, independence, quality of life and health (Links to competency 1.4). Summative assessments outlined within the course document all link with individual Nursing Council competencies and other legislation such as the NCNZ code of conduct and the Health Practitioners' Competency Assurance (HPCA) Act.

The two-week timetable linked every session to the NCNZ competencies that the session addressed. For example, the session entitled safe drug administration links to competencies 2.3, 2.4 and 2.5.



Likewise, the lesson plan for the one day back on campus mid-clinical placement was centred on discussion and reflection on practice, and how this linked to the NCNZ competencies. There was also time allocated for scenarios that revised communication, nursing assessment, and cardiopulmonary resuscitation.

The three programme documents all specifically link every lecture and session to NCNZ competencies. Combined, the course documents encompass the four domains of competence with the relevant competencies, required by the NCNZ to demonstrate safe nursing practice. These programme documents cannot be included as an appendix because it would enable the institution to be recognised.

### **The four case studies**

For the remainder of this chapter, the four cases will be presented individually in seven sections that represent the purpose of the study and the research questions. These sections are:

1. Personal and professional background: This section aims to share as much information about the participants as possible, while still maintaining anonymity, in order to build a picture of the social, cultural, and historical context of the participants.
2. Perceptions of nursing: This relates to IQN perceptions of the nursing culture and environment where they worked, providing additional context.
3. Expectations: This section explores expectations and challenges the participants anticipate, prior to their clinical placement.
4. The NZ context: This section explores IQN perceptions of the culture and environment of nursing in NZ during clinical placement. It also looks at challenges while in this environment.
5. Patient safety before clinical placement: Section five and six specifically address the research questions concerning safety.
6. Patient safety during clinical placement.
7. Transition: This section aims to capture IQN reflections concerning identity transformation/transition, and perceived challenges moving forward.

Within these sections, themes have emerged from the individual case analyses, which will be discussed. Where possible these themes are titled with the IQNs' own words.

## **Case number one: Janet**

### **Section 1: Personal and professional background**

Janet is a 39 year-old female from the Philippines, living in NZ for nearly four years. She is married with one child. Janet trained to be a nurse in the Philippines and spent two years working in an intensive care unit in a hospital setting. She then moved to Singapore where she worked for 10 years in a critical care unit in a hospital setting. This required advanced nursing skills looking after very ill patients. She was working in this setting during the SARS epidemic during which time, she stayed and cared for infected patients:

*So a lot of my colleagues resigned and we are the few who stayed back, so after that outbreak we received um a medal of valour.... We were very scared because we also had some colleagues who died.....Yeah, my families are telling me, a lot of my colleagues already resigned.....it's alright to resign, even the management want you to go, but no, we stay. (Interview one, 10 May, 2016)*

Over the ten years Janet became a senior nurse working permanent night duties where she was in charge. Eventually decisions were made to move to NZ where she completed a diploma in healthcare studies. She spent the first year in NZ on her own, until her study was completed and she had secured a job. At that time she was able to bring her husband and child over to NZ. Since then, she has worked in an aged care facility as a diversional therapist full time.

### **Section 2: Perceptions of nursing**

It is important to note that the majority of Janet's nursing experiences were in Singapore, with her experience in the Philippines being over 14 years ago, at the time of the interview.

#### ***If you don't have any other choices, you can be a nurse***

Janet talked about nursing as a profession not being respected or valued in the Philippines:

*If you don't have any other choices, you can be a nurse ... yeah because even the financial reward of it is almost the lowest. (Interview one, 10 May, 2016)*

### ***We try to be resourceful***

Janet commented on the lack of equipment and medication:

*In the Philippines, we don't have anything there we try to be resourceful, most of our instruments our medication, we don't have all those IV antibiotics.*  
(Interview one, 10 May, 2016)

### ***In the Philippines it's like spoon feeding***

Janet spoke extensively about nursing both in the Philippines and somewhat in Singapore as not encouraging critical thinking. From her perspective, nursing was task-orientated and interpretation of assessment data was left up to the doctors, regardless of the nurse's ability to interpret and act on it:

*In the Philippines it's like spoon feeding. Whatever you're taught in school that's the only thing you want to do when you get out there....but in Singapore it's still limited ... you take obs [Blood pressure, pulse, respiration rate and temperature] and go back to them [doctors] and tell them...*  
(Interview one, 10 May, 2016)

As a newly registered nurse in the Philippines, she indicated she was only confident to perform the tasks she had been specifically taught in training.

Her perception of limited opportunities for critical thinking were connected to her perceptions of a hierarchical system that did not encourage independent thinking or professional growth:

*On that hierarchy level you are not expected to perform extras and when you try to perform extras, people thought you are trying to overstep them.*

*Even in Singapore, you won't get that respect because the respect only goes to the ones on the hierarchy, because you are just at the bottom and you try yourself to perform just at the bottom, because you are not encouraged to go up.* (Interview one, 10 May 2016)

### ***You don't feel accountable***

Janet talked about accountability or lack of it in the Philippines. She rationalised that the financial resources of many people were such that they could not successfully pursue a complaint against a hospital for an error as this would involve the cost of lawyers. In light of this, Janet believed that accountability was lacking in the health system in the Philippines:

*It's just what I see, you don't feel accountable for what you have done because no one will pursue it, as long as you report it they try to close the case.* (Interview two, 8 June, 2016)

Janet described nursing in the Philippines and to a lesser extent in Singapore as a profession that was not well respected, poorly paid and a last choice for many. Lack of resources in the health system presented challenges for the nurses. A hierarchical system within the hospitals coupled with task orientated nursing training which, in Janet's view, suppressed critical thinking and problem solving. These factors may have contributed to the lack of accountability that Janet described.

### **Section 3: Expectations**

#### ***I expect a lot***

Janet had been in NZ for four years at the time of the interview and she expected to find differences in the New Zealand healthcare system:

*When I came here to NZ, I expect quite a lot from healthcare because NZ being under the first world country... I expect a lot (laughing). (Interview one, 10 May, 2016)*

#### ***Critical thinking***

Janet believed NZ nurses are independent, respected and use critical thinking in their nursing care:

*NZ nurses ... they're using critical thinking ... they don't just work following tasks. (Interview one, 10 May, 2016)*

#### ***The ones I've seen in this setting are all young ones***

Even though Janet had significant nursing experience, she acknowledged she needed to learn more in NZ, but equally, wanted to be valued for and share her experience. She was concerned that at 39 she would be considered old because she had seen many young nurses in NZ:

*The ones I've seen in this setting are all young ones. So, what they have I may not know so I may still be practicing the old practice ... I consider this all new learning, because this is a different setting, this is a different country. I will be dealing with different cultures different people ... and if I have things I want to share, I can share. (Interview one, 10 May, 2016)*

## Section 4: The NZ context

### ***...On the registered nurses level you can see the leadership***

Janet's expectations and perceptions of nursing in NZ before and after clinical placement were mostly the same. However, it appeared that nursing leadership and autonomy became a focus in her descriptions:

*On the registered nurses level, you can see the leadership on that, they are the ones taking charge so it's good to see ... they're the ones handling all the management issues ... they are very proactive and the scope is really very wide. (Interview two, 8 June, 2016)*

### ***It's overwhelming***

Janet also spoke of what she thought it must be like for nurses from the Philippines coming here with only Filipino nursing experience:

*If you are from the Philippines all your life your experience is there, it's really very difficult, it's very hard because ... the multitasking that the nurses are doing here, it's overwhelming, you find that it's too stressful, it's up to your head, you can't even perform because whatever you do, it's not even enough because you are just trying to perform on your nurse level but everybody is performing above you. (Interview two, 8 June, 2016)*

When referring to the CAP course, Janet described some of the nursing tasks as being similar to those in the Philippines. Hence, the CAP course was a means of refreshing her knowledge. However, when out in clinical placement, Janet saw the scope of the nursing role in NZ as being very different to what she had experienced. She referred to the Bachelor of Nursing degree in the Philippines as being comparable to the diploma level here. At a later date, I asked Janet to clarify what she meant by that. She responded that in Singapore the Filipino nurses with a bachelor degree needed to do more study to reach the perceived level of the Singaporean bachelor degree. Janet believed in NZ, nurses with a bachelor degree are working at a higher and more autonomous level than Filipino nurses with a bachelor degree:

*[Referring to the CAP course] It's really just a refresher because what you are doing in the Philippines is what we are doing here also, um drug calculations, how we manage patients, yeah but when you go out there ...totally different. (Interview two, 8 June, 2016)*

Janet had very positive perceptions concerning nursing in NZ, seeing it as a respected profession, which allowed for independent thought and action. Her initial

perceived challenges around being valued and respected for the experience she brought whilst being able to learn, were not mentioned after clinical placement. Janet did not seem to expect the level of autonomy and leadership skills that were demonstrated in clinical settings by nurses. This seemed to expand her perception of the scope of nursing in NZ. It also caused her to reflect on the difficulty that this autonomous environment poses for nurses transitioning from the Philippines.

## **Section 5: Patient safety before clinical placement**

### ***Safety number one***

Janet saw patient safety as the number one priority. Her initial descriptions around safety leaned heavily towards environmental safety. She spoke extensively about this, with a small portion provided below:

*At the moment the client or patient comes to your care you always look out for safety first...so before you, when you try to meet the resident or the patient in the room you try to make sure the environment is safe. (Interview one, 10 May, 2016)*

When asked to describe a situation in which she had to act to ensure patient safety, Janet spoke about an incident involving a patient in critical care in Singapore. The patient was ventilated which means he was on a breathing tube down his throat and needed to be sedated in order to tolerate that. However, he woke up from the sedation and was trying to pull the tube out because he was frightened and did not know what was going on. Janet described prioritising his care. This meant immediately preventing the patient from removing the tube and reassuring him until the doctor could be contacted for more sedation or safe removal of the tube. When Janet mentioned we, she was referring to herself and another nurse.

*We are the ones there so we are the ones who try to hold him down, try to calm the client, try to talk, we need to reassure them first, we need to explain what's happening and why are all those things with them because he just woke up. (Interview one, 10 May, 2016)*

## **Section 6: Patient safety during clinical placement**

### ***Patient safety.... it's still the same for me***

During clinical placement Janet described her perceptions concerning the concept of patient safety as being the same as her perceptions described before clinical

placement. At the same time, however, she observed that the health system in NZ had a strong emphasis on this issue:

*Patient safety is a priority here and there's quite a lot of nurses for patient safety and they are really protected here. Simple things like neglecting them is not really that big an issue in the Philippines. (Interview two, 8 June, 2016)*

Janet spoke about accountability and investigation into errors being very important in NZ as opposed to the Philippines. She explained that here in NZ the health consumer will challenge the mistake and will rectify it and be accountable for it, whereas in the Philippines that was not the case:

*I mean it's not really a big deal if you've done something wrong, [in the Philippines] like for a medication error you will just do a paperwork, report it and that's it, its fine, but here, no there's a lot of investigation going to happen ... then at the end they try to make amendments like if there's any need for changing. (Interview two, 8 June, 2016)*

Janet's perceptions of patient safety initially appeared to centre on keeping the environment safe for the patient to prevent falls or accidents. However, when reflecting on incidents in her nursing career regarding patient safety, Janet described prioritisation of care, problem solving, and communication skills. After being on clinical placement, Janet did not appear to have a different view of safety but did recognise that it was a priority in NZ. She reflected that having what she perceived as adequate numbers of nurses helped, but also that the health consumer expectations for receiving safe nursing care had a big part to play.

## **Section 7: Transition**

When thinking about where to from here, Janet expressed excitement at all the possibilities available to her in NZ and the transition process did not appear to be worrying her:

*It felt good to be taking charge again, doing all the usual RN scope like following Dr's rounds, liaising with District Nurse for wound management..... Can't wait for next year looking up for RN jobs and hopefully going back to study again. (Email reflection, 27 June, 2016)*

### ***Already moulded by the culture***

Janet believed that being out of the Philippines for 14 years had changed her significantly. She felt because of the moulding that had happened outside of the

Philippines, she would no longer be able to nurse there, stating it would upset her too much.

***I find it will just be experience***

Janet spoke about her concern for her fellow compatriots and worried about the difficulty of their transition process. She felt that time, experience and patience with these nurses was required for a successful transition to practise in NZ. She also spoke about how she perceived their responsibilities in this process:

*...they have to be open ... because I also feel that with my same countrymen, I try to give them more information like, for example they are new in the facility ... they don't take it positively, even if you are the one from the same country, you are trying to help them ... they're not open to all those changes.*

*...it should be on their own learning too, because when you see the system, you see everyone do like that, you have to keep up with them, you don't just keep to yourself and just perform to what level you know. (Interview two, 8 June, 2016)*

Janet was a mature woman with perceptions of nursing in the Philippines, Singapore and NZ. Having been out of the Philippines for over 14 years, she was able to provide interesting reflections on the culture of nursing in the Philippines as it was in her time in light of the remoulding process that happened to her in both Singapore and then four years in NZ prior to the CAP course. Even with this insight, Janet was introduced to many new insights and focuses in the NZ nursing culture and environment that she would need to adapt to in order to transition successfully.

**Case number two: Bibo**

**Section 1: Personal and professional background**

Bibo is a 26 year-old male from the Philippines. He had been living in NZ for one month at the time of the interview. Bibo describes himself:

*...then I went to university, one of the good schools there in the Philippines ... I really didn't want nursing first and I based my course on my math grade from high school and I said to my mum if my grade is 85 and above I'll go for engineering and if its 84 and below I'll go for the most common course at that time which was nursing, so when the result came it was 84 so I will do my part of doing the deal so I go for nursing, then as time goes on I really love it. (Interview one, 18 May, 2016)*



Bibo came to NZ on his own, leaving his family and girlfriend at home:

*I've got my girlfriend at home who's also a nurse. I'm telling her already, yeah come, take the IELTS and come over here. I'm staying, I call them like my foster parents because they know my parents in the Philippines ... so my parents can sleep at night. (Interview one, 18 May, 2016)*

Bibo spent two years after graduation working in the operating theatre.

## **Section 2: Perceptions of nursing**

### ***Competencies***

Having been introduced to the NCNZ competencies for registered nurses (in the CAP course), Bibo was able to make comparisons with nursing in the Philippines. He described a task orientated system with a final exam. Having seen the specificity of NCNZ competencies, he felt the Philippine competency assessment format was very broad:

*...um in the Philippines because we don't have like their competencies we have like a board exam. In my time before we can take the board exam we should have like assisted 5 minor operations in theatre and another 5 major ones, then in delivery you should have 5 assists ... a total of 25 things to do. That's our requirement for our professional regulation commission, that's like our nurse council so that's I think super broad. (Interview one, 18 May, 2016)*

### ***I'm just like plankton compared to a doctor***

Bibo described a hierarchical system where nurses felt undervalued and consequently had little hope of career advancement:

*We can't voice our opinion especially when it's a matter of seniority regarding doctors, they are always like douche bags, they think the nurses are just like their staff.*

*...I told them it's always been hierarchy in the Philippines; the doctors are always the captain of the ship so they get this attitude of being very bossy. (Interview one, 18 May, 2016)*

Bibo described a nursing colleague, who recognised the difficulty of nursing in the Philippines and how it needed to be encouraged at the student level to the point that he was prepared to give good assessments regardless of students' abilities:

*I remember one colleague, he said when he rate students he rate a perfect score even when they make a mistake and even us, because his point of view is that the moment this guy wakes up, comes here to work, just for school, that's already an effort there even though there is mistakes. (Interview one, 18 May, 2016)*

Bibo also described a situation that he encountered eighteen months into his nursing career where he was advised by a senior colleague to leave the Philippines and nurse elsewhere if he wanted to advance in his career:

*He told me that, um, not to stay long ... then he told me that if you really want to strive more Bibo quit right now, take the IELTS, process it and go.*  
(Interview one, 18 May, 2016)

### **Resources**

Bibo described the public hospitals in the Philippines as having major resource issues, affecting both staff and patients:

*...limited supplies, oxygen masks...just swabbed out, also not all patients get chest x-ray so we don't know if he or she has pneumonia or tuberculosis.*  
(Interview one, 18 May, 2016)

Bibo painted a picture of a task orientated system for nursing training in the Philippines. Lack of resources and minimal potential for advancement, coupled with a hierarchical system where nurses were not well valued, appeared to encourage migration of nurses to find better employment opportunities.

## **Section 3: Expectations**

### ***Again I will be back to plankton level!***

Bibo did not refer to his perceptions of nursing in NZ prior to clinical placement but did speak about the challenges he expected to encounter. It is clear in his statements that he had concerns around being treated like he was in the Philippines:

*I think the biggest challenge is that I will be new to the place ... I think the second problem is the language barrier... I think the next is my role, finding out, because I'm not a nurse yet, I'm still like a student. Again I will be back to plankton level ... ok maybe a fish!*

*...if there's a toxic doctor that would shout, of course that will be like...nasty and make me return to a seed.* (Interview one, 18 May, 2016)

## **Section 4: The New Zealand context**

### ***It was a blast***

Bibo's initial response to his clinical placement was excitement despite the challenge of learning. He appeared energised by his experience:

*So far, one week and two days into the placement, it was a blast though I had to learn and adapt as fast as I can to do things on my own. Needed to adjust to the set up (environment), people (good thing they were so nice and helpful) and especially my role as a CAP student. (Email reflection, 31 May, 2016)*

### ***You're a part of the team***

Bibo's discussion after having some time in an operating theatre in NZ provided a stark contrast to his expectations prior to placement. He repeated several times how much he enjoyed feeling part of the team:

*So the difference there is when I came there, oh ok you're part of the team, they are very welcoming, even the top of hierarchy in there, the coordinators, the managers ... Oh you're Bibo right you're the CAP student and something like that ... come Bibo, come join the group ... they won't start until I go there. You will be able to discuss the cases for the day so that's very comforting even though I'm a CAP student so that's it. Yeah, they're always asking me how are you Bibo? (Interview two, 8 June, 2016)*

### ***She makes the competency so you can easily understand***

During interview Bibo had expressed concern over his competency self-assessment (a CAP course requirement); however, he described a nurse he worked with on placement named Sharon (pseudonym) who helped him translate the NCNZ competencies in a way that he could understand and see how they were applied in practice. This had a significant impact on Bibo's understanding of nursing in NZ:

*Sharon was really good, she makes the competency so you can easily understand it ... she really help me a lot.... Sharon told me that these competencies are just done every day, you just don't know you're doing it actually ... like we will always ask every patient or every family, is there anything else you want to tell us, individual needs or ethical needs. We always ask that so that's the objective of being a nurse. (Interview two, 8 June, 2016)*

### ***...it's all going to the middle to the patient***

Bibo saw a pleasant physical environment, with teamwork and collaboration amongst the nursing staff in New Zealand that centred on patient care. He felt that there were enough staff in New Zealand to allow such collaboration. He believed that poor staffing levels in the Philippines meant that the team was so stretched that they worked much more as individuals as opposed to a team:

*Theatres here in NZ are so tidy, spacious, organized, and nurse friendly. It benefits both employees and patients a lot. (Email reflection, 31 May, 2016)*

*It's really cool here in NZ because in the Philippines it's like the patient and you ... here it's like a cobweb that the patient must connect together, it's all going to the middle to the patient. (Interview two, 8 June, 2016)*

Before going to clinical placement, Bibo's expectations were cloaked in the environment he had come from. Therefore, his expectations and perceived challenges were related to that. However, after his clinical experience, Bibo described a very different situation. His understanding of the NCNZ competencies in practice were helped by a preceptor in the clinical environment.

## **Section 5: Patient safety before clinical placement**

### ***We come to nursing to save lives, not to make more harm***

Bibo summarised patient safety as doing no harm, achieved by having a rationale for the nursing care:

*The number one thing is that no matter what you do you always have to think about the patient safety because we come to nursing to save lives, not to make more harm ... everything you do ... you already have a rationale for that action. (Interview one, 18 May, 2016)*

### ***We don't want you to suffer***

Bibo described a situation in which he had to act to ensure patient safety. This was in the part of the theatre where patients recover after an anaesthetic, before returning to the ward. Bibo was looking after a patient who had had surgery to his arm and leg after a bike accident while he was drunk. In the recovery room the patient became agitated, demanding a drink of water. Bibo described in detail how he tried to prevent the patient having the water because it was likely to cause him to vomit. He was patient and worked creatively with this patient. He stayed after his shift had finished because he had developed a rapport with this man which enabled him to stay calm until such a time that he could safely have a drink of water (Interview one, 18 May, 2016).

## **Section 6: Patient safety during clinical placement**

### ***It will always be the priority***

Bibo talked again about doing no harm and not just doing routine tasks, but really taking that extra care to do the job well. Bibo also talked about nursing assessment always being the key to patient safety:

*I think it is, no matter what happens it will always be the priority because the patients come into hospital to be better ... so safety must always be extra care rather than doing the routine. (Interview two, 8 June, 2016)*

Bibo again referred to adequate staffing levels that enable better management of patient safety and prevention of harm:

*There should always be two nurses a scrub nurse and another nurse or another person even an orderly to be around (in theatre) just to provide extra safety to the patient. (Interview two, 8 June, 2016)*

Bibo's perceptions concerning patient safety did not appear to shift noticeably before or after clinical placement. He remained focused on the patient not being harmed. An adequate number of staff in regard to patient safety was consistently seen as important.

## **Section 7: Transition**

Bibo's initial fears relating to language did not appear to be an issue during placement. He talked about how he felt his nursing practice had changed during clinical placement:

*The challenge I thought was first was communication but then it's not really that hard when you get used to it and you just keep on talking to people because if they can't understand you they will just ask you to repeat what you've said.*

*I've been reflecting that I've been a better nurse since I've been exposed in a NZ setting, because I've been more, I always ask further questions.*

*... I've been saying if you need anything just call us we're just around... (Interview two, 8 June, 2016)*

### **How it is to be a nurse in NZ**

Bibo related how, after spending five weeks in clinical placement he felt he had begun to work independently, listing many of the tasks he was performing and equating this achievement with working again as an RN. He added that he was beginning to see what it was like to work as a nurse in NZ:

*I felt I was in proper tune of what I do in the Philippines. Also, the nurses have taught me a lot of bits and pieces of their own knowledge how it is to be a nurse in NZ. (Email reflection, 28 June, 2016)*

The concerns Bibo had prior to clinical placement about communication and being made to feel small were not realised. He was very excited about because these concerns were not reflected in the reality of the placement. When referring to the

transition process, Bibo's last two statements above are very powerful beginnings of this process that Bibo himself recognised.

### **Case number three: Rachel**

#### **Section 1: Personal and professional background**

Rachel is a 32 year-old woman from the Philippines who had been living in NZ with her partner for three years. Rachel studied and trained for nursing in the Philippines.

*I've studied at my college four hours away from home so I stay there for six to seven years because I have to do also four years of nursing, one year do my review and my exam. (Interview one, 18 May, 2016)*

Rachel worked for two years in an operating theatre in a hospital in the Philippines, then ten months in a postoperative ward, and finally another ten months in theatre again. Following that she applied for a student visa for Australia and moved there. She studied aged care and was there almost two years:

*I was studying, so I worked as a health care assistant in a rest home in Australia and then after that I was trying to get my registration ... but I couldn't focus on my English exam because I have to juggle three jobs. (Interview one, 18 May, 2016)*

On a friend's advice, who was working in NZ, Rachel came to NZ and worked as a health care assistant in aged care facilities for almost three years before applying to attend a CAP course:

*...so I have a lot of experience getting to know a lot of people.... I enjoy conversing with them because I learnt a lot as well ... I like their food ... I like to know a lot of cultures especially with the festivities they are having, so I enjoy that. (Interview one, 18 May, 2016)*

#### **Section 2: Perceptions of nursing**

Rachel described some of the tasks that were required of her during her nursing training. This particular description concerned a month of clinical experience in the mental health environment:

*We have activities with our patients ... we studied a lot ... and then we do the case study, we have to present it in front of our instructors ... nerve racking ... we did a lot of nursing care plans ... drug rounds, everything. (Interview one, 18 May, 2016)*

### ***I'm just afraid of being told off***

Rachel's descriptions of her experiences centred on her learning experiences and eagerness to learn. Throughout these descriptions were comments around fear relating to the hierarchical structure in the Philippines:

*Hierarchy is more comfortable here than in Philippines, it's scary. It's a scary experience in the Philippines.*

*I don't feel shy to ask ... because I want to learn more ... If I can sense that the surgeon is really in a good mood ... if he's not in a good mood then don't ask ... so I'm not afraid to ask, I'm just afraid of being told off. (Interview one, 18 May, 2016)*

### ***In the Philippines the nurses' role there is very heavy***

Rachel described how the role of the nurse in theatre in the Philippines is not clearly defined because of the shortage of staff. She explained that there were no anaesthetic technicians and so a nurse would have to do their own work, some of the anaesthetic technicians work and anything else the surgeon may ask for.

In all Rachel's descriptions concerning nursing training and work as a registered nurse there was a focus on the many tasks, and a focus on Rachel's learning. As mentioned above, interwoven in these descriptions were snippets that suggested a culture of fear of authority, which Rachel was aware of but appeared to overcome because of her eagerness to learn.

## **Section 3: Expectations**

Rachel's perception of nursing in NZ centred mostly on resources and the role of the nurse.

### ***More advanced, I think***

Rachel stated that she expected different conditions for nurses in New Zealand:

*I've heard the practice of um nursing here is different in the country because um in here you have the health care assistant*

*More advanced I think. Of course NZ is more advanced ... like for example the instruments, equipments... (Interview one, 18 May, 2016)*

## **Section 4: The New Zealand context**

### ***I have to take note of the culture in here***

Rachel felt that the interview process for new admissions in hospital was in essence the same as in the Philippines but did note, however, that cultural awareness was

important. She also noted that asking for information from parents about child patients was important, which may not have been the practice in the Philippines:

*Interviewing is much the same but I have to take note of the culture in here as well because there are a lot of different cultures.*

*...if they are a child you know I ask their parents or most of all it's to ask the parents and so asking them you have to assess the child as well. (Interview two, 8 June, 2016)*

Rachel noted that nurses in theatre in NZ have a specific role, whereas in the Philippines those roles are less well defined, related to staff shortages:

*Its um, they have a specific role here, like this is for the nurse ... if you are a nurse you have to do this and this only. (Interview two, 8 June, 2016)*

Rachel did not appear to see much of a contrast between the Filipino operating theatre environment and NZ's, except for greater role definition and resources. She articulated some differences in the approach to patients with regard to culture and respect.

## **Section 5: Patient safety before clinical placement**

### ***First things first***

Rachel firstly thought of the environment when discussing patient safety but then progressed to assessment of risk and monitoring patients as part of safety. "First things first" suggests a systematic approach to patient safety:

*Um the environment, you just have to check the environment for the patient safety, just assess the patient, what he needs.*

*...first things first, he's already on the operating table just make him safe because we put the straps so we have to make that safe and secure on the table and what else, attached to the monitor everything, vital signs ... you regularly monitor the patients, circulation, everything. (Interview one, 18 May, 2016)*

### ***I'd rather ask to be safe***

As Rachel said previously, asking can be a scary thing in the Philippines but she stated here that it is very important with regard to patient safety.

*I notice as well some nurses don't ask, they just pretend that they know it but I'd rather ask to be safe, than to know everything and harm to the patient. (Interview one, 18 May, 2016)*



When asked to describe a situation where she had to act to ensure patient safety Rachel described an experience she had in the operating theatre in the Philippines. The anaesthetist needed to take an urgent call outside the theatre while an operation was in progress, asking Rachel to monitor the patient while he was gone. The surgeon was not informed that the anaesthetist had left and that Rachel was monitoring the patient. Rachel was taking the patient's blood pressure and it became dangerously low. She repeated it three times over a period of minutes and it remained low. Again the surgeon was not informed that this was happening. The anaesthetist had not returned so Rachel fast tracked the intravenous fluids and prepared the appropriate medication to help rectify this problem. She then ran and informed the anaesthetist of the situation. He returned to the theatre, gave the medication Rachel had prepared and commended her on her actions. This situation depicted critical thinking and problem solving ability on Rachel's behalf.

## **Section 6: Patient safety after clinical placement**

### ***I think it's the same***

Rachel's perceptions did not differ after her clinical placement:

*I think it's the same ... because when we are doing the job as a nurse I think first for the patients. (Interview two, 8 June, 2016)*

Rachel described patient safety but only pertaining to patients in theatre. She also felt there was no difference between the Philippines and NZ in regards to patient safety. This may partly be due to the fact that she was describing the environment in an operating theatre which tends to be a routinised environment.

## **Section 7: Transition**

### ***It's very very big changes to do***

In referring to the big changes, Rachel talked about learning the different procedures, equipment, policies and nursing roles, as opposed to a different culture of nursing. This was consistent with how she described her approach to learning in the Philippines. She saw the nurse's role in NZ as much more defined and therefore wanted to make sure she did not step outside that role. That was what she referred

to regarding code of conduct. She also reflected on how much she enjoyed her clinical placement and the teamwork:

*I think it's a big challenge. I'm starting to adapt but I still have a lot of things to learn as a RN [registered nurse] here. It's very very big changes to do.*

*I can tell that maybe I can adapt as long as I can always remember the code of conduct. (Interview two, 8 June, 2016)*

### ***I love how they work as a team***

*I really enjoyed my placement. All the staff were so helpful and very approachable. I love how they work as a team! (Email reflection, 1 July, 2016)*

Overall, Rachel did not see vast differences between nursing in NZ and the Philippines. This may be attributed to most of her experience being in the operating theatre. Without perhaps articulating it directly, however, some comments alluded to a system where there was hierarchy and fear. Rachel's last comments reflect her enjoyment of the friendly environment and teamwork she experienced in clinical placement.

## **Case number four: Andrew**

### **Section 1: Personal and professional background**

Andrew is a thirty year-old male from the Philippines, who is married and has been living in NZ for two years. Andrew had around four years post-graduate experience in several areas of nursing in the Philippines. He worked in both private and public hospital settings in paediatric and adult nursing. He described a volunteer system he went through in order to secure a registered nurse paying job. This meant that for much of his time in the Philippines he was not being paid for his work:

*In the Philippines if you need a pay in the government [hospital] you need to apply with the governor. (Interview one, 18 May, 2016)*

Andrew's wife moved to NZ in 2012 and secured their visas while over here.

She works as a nurse in NZ:

*...and she apply the resident visa together with my papers so she took me out of poverty (laughing). (Interview one, 18 May, 2016)*

Andrew came to NZ in 2014 and has worked in an aged care facility as a health care assistant since then.

## Section 2: Perceptions of nursing

Andrew described his experiences of nursing in the Philippines in the private and public hospital settings, providing contrasting perceptions of the culture of nursing in the Philippines in some healthcare settings:

*...If there's something wrong with the situation ... they are going to suspend you.*

Andrew described a culture of blame when he talked about his private hospital employment, illustrated by the statements below:

*...because my biggest experience with a private hospital, they're not really supporting their employees so if there's something wrong with the situation... they're going to suspend you and after suspension you're out.*

*....my previous experience in a private hospital we were counting the medication and if you are missing one you have to trace it. I was charged with omeprazole and I didn't take it. After several years they discovered a nurse attendant was taking it and selling it in a government hospital. (Interview one, 18 May, 2016)*

### ***Even the patient won't complain***

Andrew described the public hospital setting as where health consumers would not complain and if a patient is difficult, they can be removed:

*In the government setting the nurse are always very demanding ... and even the patient won't complain if the nurse will get angry, they will keep their mouth shut. In the private setting it's different, it's something like in here that you need to respect them. (Interview one, 18 May, 2016)*

### ***Lack of resources***

These descriptions apply to the public hospital setting. Andrew talked about the difficulty of not always being able to give the medication that a patient required because of lack of resources. When he talked about having no money he was referring to the hospital. He also described lack of beds, space and appropriate equipment:

*...in government hospital every time doctors order a medicine....we're the one going to pay and we got no money, sometimes really sad... to put down, no medication, unable to comply.*

*You're really busy with a lot of patients in our setting because we use the alley to put beds because there's too much especially on rainy days, dengue season, it's really common in the Philippines so we put a lot of folding beds outside. (Interview one, 18 May, 2016)*

In the private hospital setting Andrew perceived that patients were respected and resources were perhaps better. However, the nurses themselves appeared to work under strict conditions and had little right of say. In the public setting this may have still been the case, but Andrew focused less on that and more on the demands of an under-resourced setting. Despite this, he spoke of enjoying his public hospital nursing more.

### **Section 3: Expectations**

Andrew did not refer much to what it would be like nursing in NZ. What he did say was related mainly to resources. His primary concern was his ability to communicate effectively with English being his second language.

#### ***English is my second language...***

Andrew perceived that his fluency in English could make it difficult for him to communicate:

*English is my second language so my challenge will be to explain to them [patients] in simple terms like directing them a simple task. (Interview one, 18 May, 2016)*

### **Section 4: The New Zealand context**

Andrew compared the rest home environment of his clinical placement to the hospital environment that he had experienced in the Philippines. He found blister packs, which are pre-packaged medications from pharmacies, prepared for patients to be given in rest homes, an unfamiliar concept which he found challenging.

#### ***I am still adapting...***

Andrew was also aware that he was nursing in two very different contexts:

*I am still adapting with the new system ... medication charts are also different... (Email reflection, 31 May, 2016)*

*Actually it's quite different because I've never been to a rest home facility [in the Philippines] ... which in here I've been working only in a rest home. (Interview two, 8 June, 2016)*

#### ***The challenge would be to talk with the family***

Andrew remained concerned about his communication skills, in particular, phone calls and speaking to families about what he perceived to be negative outcomes:

*The hardest would be to inform the family about falls and patients who passed away or any negative things that have happened ... you know my weakness when it comes to English and I hate talking on the phone. (Email reflection, 31 May, 2016)*

When describing the culture of nursing in the Philippines Andrew articulated how he felt and what it was like for him working in that environment. This was not articulated so much when talking about the NZ culture of nursing. It may take more immersion in the environment to develop that perspective. However, Andrew related anxiety regarding communication and, in particular, phone conversations.

## **Section 5: Patient safety before clinical placement**

### ***Patient safety would be our focus always on our patient***

When discussing the concept of patient safety Andrew listed a wide spectrum of ideas. These included risk of falls assessment, health education, and documentation, managing bodily functions such as bowel motions and urine output, and managing intravenous fluids safely without an infusion pump:

*So, for me patient safety would be our focus always on our patient, like for example someone who has some stroke or dementia ... I always prioritise the patient instead of waiting for them to fall.*

*And of course with IV fluids, make sure they were flowing well because we don't have infusion pump... (Interview one, 18 May, 2016)*

Andrew described a situation that he had to manage in order to give the patient the best and safest care he could with the resources available to him. He thought through the principles that he needed to apply in order to safely administer blood to an infant without an infusion pump:

*There was a case when the doctor ordered something like a small amount of blood transfusion and you couldn't push it so I really need to be creative.... I talked to the paediatric doctor, I explained to him this is what I'm going to do, so I set up an intravenous line and a blood bag with a filter and I just extract 3cc there then the line with the plane NS and then I closed the main line and I put the blood going to the tube, I got no choice, it's the best way I can do. (Interview one, 18 May, 2016)*

## **Section 6: Patient safety during clinical placement**

### ***I think they are more particular with the safety here in NZ***

Andrew's comments were mainly based on hazard awareness and prevention which he had not noticed as being a priority in the Philippines:

*I think they are more particular with the safety here in NZ, especially the teaching about hazard, they really put it in every place..... They're doing a fire drill every 6 months and I couldn't remember the last time I had a fire drill in the Philippines. They're checking us with handwashing, how to do it every 6 months as well. (Interview two, 8 June, 2016)*

Andrew did not appear to have different perceptions of patient safety after exposure to nursing in NZ. His main comments were centred on a more rigorous focus in NZ on prevention, with strict policies concerning these issues.

## **Section 7: Transition**

When looking ahead, the most important thing for Andrew was finding a job. He then, it seemed, wanted to fit in quickly. After his descriptions regarding the management style in the government hospital in the Philippines, Andrew was looking forward to having a good manager, and adapting and working well with colleagues:

*To adapt really fast and to get on well with your colleagues, that's really important and I'm looking forward for good manager. (Interview two, 8 June, 2016)*

### ***It was a stressful experience***

Andrew's number one concern continued to be communication. However, despite this he seemed to be able to see some positives in the process:

*I attended the multidisciplinary team meeting with family. It was a stressful experience to hear all the complaints and how we can make a solution. On the other hand, some family members like the progress of the resident from being isolated to socially interactive. Overall it was a relief that I finally finished the programme and excited to face the new challenges ahead of me. (Email reflection, 27 June, 2016)*

Andrew was keen to get a job and adapt to nursing in NZ. He continued to be nervous about his ability to communicate well despite the fact that during the interview process he communicated very effectively and was assured of that. He also placed a lot of self-imposed pressure to adapt quickly. Despite this he had hopes of working in a hospital setting, as that was what he had loved in the Philippines.

## **Conclusion**

This chapter has presented a summary of the findings that emerged from the data collected in this study. Chapter five will discuss these findings.

## **Chapter Five: Cross-case analysis and discussion**

### **Introduction**

This discussion chapter will synthesise, summarise, and discuss the main themes that emerged across the four cases outlined in Chapter four. Table 3 provides a summary of those themes. Multiple-case study was chosen as the design for this research to investigate a complex phenomenon with the understanding that the contextual conditions were of utmost importance to the phenomenon under investigation (Yin, 2014). The phenomenon was the IQNs' perceptions of patient safety during their transition to a new health system.

This chapter is divided into three sections. The first discusses IQN perceptions of safety at the beginning of the CAP course, within the social, cultural, and historical context of the participants. Using the CoP concepts of mutual engagement, joint enterprise and, shared repertoire, section two examines the IQNs' experiences of being introduced to NCNZ competencies through the CAP course and the impact on their perceptions of competencies related to patient safety. Section three combines and summarises IQN perceptions of patient safety, before and after the CAP course. Findings will then be discussed.

**Table 3. Summary of the themes across the four cases**

Sections	Janet	Bibo	Rachel	Andrew	Summary of theme
<b>Section 1 Personal and Professional background</b>	Female, aged 39, married with one child. Two years working in the Philippines in Intensive Care. Ten years in Singapore in Critical Care. Four years in NZ, working as a diversional therapist in aged care	Male, aged 26. He has a girlfriend in the Philippines. Two years working in theatre in the Philippines. One month in NZ	Female, aged 32. She has a partner here in NZ. Two years and 10 months working in theatre and 10 months working in a post-operative ward. Two years in Australia studying and working as a healthcare assistant in aged care and 3 years in NZ working as a health care assistant in aged care.	Male, aged 30. 4 years working in ward settings in public and private hospitals in the Philippines. Almost 2 years working as a health care assistant in NZ in an aged care facility.	Diversity of age, gender, lifestyle and professional experience
<b>Section 2 Perceptions of nursing</b>	<p>Resources</p> <p>“If you don’t have any other choices you can be a nurse.” “You don’t feel accountable.”</p> <p>“In the Philippines it’s like spoon feeding.”</p>	<p>Resources</p> <p>“I’m just like a plankton compared to a doctor.”</p> <p>Competencies.</p>	<p>“In the Philippines the nurse’s role is very heavy, they have to do everything.” “I’m afraid of being told off.”</p>	<p>Lack of resources.</p> <p>“If there’s something wrong with the situation they’re going to suspend you.” “Even the patient won’t complain.”</p>	<p>An under-resourced health system</p> <p>A hierarchical health system where power relationships were evident and nursing was perceived to be near the bottom. Fear and blame prominent.</p> <p>A task focus on nursing training.</p>
<b>Section 3 Expectations</b>	<p>“I expect a lot.”</p> <p>“They can decide using their own critical thinking.”</p>	<p>“Again I will be back to plankton level.”</p>	<p>“More advanced I think.” (regarding resources)</p>	<p>“English is my second language.”</p>	<p>Expectations of a better resourced health system.</p> <p>More autonomy in the nursing role.</p> <p>Concerns relating to acceptance/competency and</p>



Sections	Janet	Bibo	Rachel	Andrew	Summary of theme
	"The ones I've seen in this setting are all young ones."				place within the NZ health setting.
<b>Section 4 The NZ context</b>	<p>"On the registered nurse level you can see leadership."</p> <p>"It's overwhelming"</p>	<p>"It's all about the patient." "It was a blast You're part of the team." "She makes the competency so you can easily understand."</p>	<p>"I have to take more note of the culture in here."</p>	<p>"I am still adapting." "The challenge would be to talk with the family."</p>	<p>Holistic focus with patient care. Excitement relating to nurses' role in NZ  Challenges and evidence of transition</p>
<b>Section 5 Patient safety before clinical placement</b>	"Safety number one."	<p>"We come to nursing to save lives, not to make more harm." "We don't want you to suffer."</p>	<p>"First things first." "I'd rather ask to be safe."</p>	"Patient safety would be our focus always on our patient."	Patient safety is high priority and the focus of nursing care.
<b>Section 6 Patient safety during clinical placement</b>	"Patient safety um somehow it's still the same."	"It will always be the priority."	"I think it's the same."	"I think they are more particular with safety here in NZ."	<p>Perception that safety is the focus of nursing care stays the same. Some evidence of seeing system differences in management of patient safety between NZ and the Philippines.</p>
<b>Section 7 Transition</b>	<p>"Already moulded by the culture."</p> <p>"I find it will just be experience."</p>	"How it is to be a nurse in NZ."	<p>"I love how they work as a team."</p> <p>"It's very very big changes to do."</p>	<p>"It was a stressful experience."</p>	<p>Evidence of transition and understanding of the nurse role in NZ Prior personal experience of transition. Understanding of the ongoing challenge and time required for transition.</p>

## Section 1: IQN perceptions of patient safety before clinical placement

The primary research question in this study asked how the IQNs perceived the competencies that pertain to patient safety. In CoP theory, competence is defined by the individual CoP and is where IQNs' understanding of competence and professional identity are constructed (Wenger, 2000). Therefore, using CoP theory, IQN understanding of the competencies that pertain to patient safety will have been constructed within the nursing and healthcare CoP described by the participants in their data.

When asked about patient safety prior to their clinical placement, all the participants said that patient safety was the first priority and focus for them when caring for patients. Regarding the competencies that are required to maintain patient safety, three out of the four participants' responses focused on creating and maintaining a safe environment for patients. Other interventions included monitoring vital signs, documentation, and various other nursing tasks. Rationale for nursing interventions in patient care was mentioned by one participant as key to safe nursing practice. The IQNs' descriptions of situations where they had to act to ensure patient safety provided additional insight to their initial answers. The participants described four very different scenarios, but each situation required some level of assessment, prioritisation of care, communication, and problem solving skills. Table 4 summarises these perceptions.

**Table 4. Participant perceptions of patient safety at the beginning of CAP**

Summary of participant perception of competencies pertaining to patient safety at the beginning of CAP	Additional characteristics of patient safety evident in individual participants' description of nursing care.
<ul style="list-style-type: none"><li>• Patient safety is the number one priority of nursing</li><li>• Monitoring and maintaining the environment to ensure safety</li><li>• Asking questions when you don't know</li><li>• Having rationale for decision making</li><li>• Health education for patients</li><li>• Documentation of patient information</li></ul>	<ul style="list-style-type: none"><li>• Assessment of patients</li><li>• Priorities of urgency in patient care</li><li>• Communication with patients and other staff members</li><li>• Problem solving to manage complex situations</li></ul>

## **Social, cultural and historical context of participant perceptions**

The participants' perceptions concerning patient safety are now discussed in relation to the data that provided the social, cultural, and historical context of the participants' prior CoP. Although the four participants had trained and worked in the Philippines, there was significant diversity amongst them in age, gender, family circumstances, and previous nursing experience. However, the data revealed two themes that were common to all four participants. The first of these related to the resources in the health sector in the Philippines. The second was a clearly defined hierarchical structure in the health system that appeared to create very evident power relationships. These themes are discussed and related to the participants' accounts of patient safety.

### ***Resources***

The four participants emphasised an under-resourced healthcare setting in the Philippines. They reported a lack of space to accommodate patients and a lack of the appropriate medications to manage patients' conditions as well as a lack of equipment, ranging from basic equipment such as oxygen masks to intravenous pumps. Furthermore, a lack of staff to adequately cater for patients' needs meant that the IQNs described their roles as being very heavy and stressful with responsibility for multiple numbers of patients and tasks.

The context of resources was reflected very clearly in one of the participants' descriptions of having to problem solve and improvise when he did not have the appropriate equipment to adhere to the guidelines for administering blood to an infant. (Refer to p. 54)

### ***Hierarchical structure and power relationships***

The participants also described a hierarchical healthcare system in the Philippines that resulted in explicit power relationships among staff members. The nurse clearly sat at the bottom of this structure, with very little power and voice, the doctors being at the top. Descriptions of encounters with doctors, senior nurses and managers reflected these power relationships. Power relationships are also reported in other sectors outside the health system in Asian culture (Pearce, 2012). The nurses' rank in this hierarchical structure appeared to be associated with IQN reports of nursing in the Philippines being regarded as a poorly respected profession with low pay. This was also seen in one participant's description of the Singapore setting as well.

### ***Impacts of the power relationships***

There appeared to be several impacts on the participants in this system as a consequence of these power relationships. The first, and perhaps the most prominent, portrayed by three of the participants, was a culture of fear. While three of the participants explicitly expressed fear in relationships with doctors and senior colleagues, the older more experienced participant did not. These are supported by Filipino nurses in Lin (2014) who reported fear of disagreeing with authority figures. An example in the data where fear may have impacted a situation was in one of the participant's descriptions of where a surgeon operating on a patient was not informed as to what was happening when the patient's safety was in question. (Refer to p. 49). Another participant expressed concern that because of his experience with doctors in the Philippines, if a doctor was unpleasant to him in NZ it would cause him to retreat into himself.

A further impact of this hierarchical structure was that nurses appeared to have limited opportunity to develop critical thinking or problem solving skills. Nursing training was portrayed as focused on learning tasks and then, once registered, just performing those tasks. Filipino and Chinese IQN participants in a Canadian study stated that they were not allowed to do anything without a doctor's permission in their respective countries (Van Kleef & Werquin, 2012). Similarly, Lin (2014) reported that independent decision making was not considered part of the nursing role in the Philippines. The participants' data in this study revealed a heavy focus on tasks and a reliance on doctors for interpretation of patient information. Their descriptions of situations relating to patient care did, however, appear to involve levels of critical thinking and problem solving, which are skills represented in the NCNZ competencies (NCNZ, 2016).

A further impact of this hierarchical structure was that patients appeared to have little power or voice, particularly in the public health system. Similar findings relating to the nurse-patient relationship were found in the following studies. IQN participants in Peisachovich (2015) stated that at home they did not talk to the patients much. This finding is corroborated by IQNs in Canada who stated that they only concentrated on the patient condition but not on communication with the patient themselves (Van Kleef & Werquin, 2012). Similarly, Filipino IQN participants in Lin (2014) reported not being taught or encouraged to consider or advocate for

patients' rights. Patients pursuing legal action against healthcare professionals for errors was reported to be an unfamiliar concept by the same participants (Lin, 2014). One participant in this study also spoke of patients pursuing legal action in the Philippines as being rare. Furthermore, in this study, because patients did not have power in the overall structure of healthcare, there may have been less accountability for the actions of the healthcare professionals. This was implied in accounts of patients not complaining when a nurse was angry with them and the practice of not assessing student nurse and nurse competence with patient safety in mind. (Refer p. 41). Two of the IQNs' accounts concerning patient safety involved communication with the patient; one in particular involved ongoing negotiation and discussion with a patient. However, none of the accounts appeared to represent patient power of choice in their care. Filipino IQN participants in Lin (2014) found it very difficult to adjust in the United States to a system where patients had the right to make choices concerning their treatment options.

In summary, the participants in this study have been trained in a health system and culture that they have described as having limited resources and a hierarchical structure that appeared to limit development of critical thinking and problem solving skills. It also generated fear of authority and suppressed individuals' ability to be assertive and to advocate either for themselves or their patients.

Section 1 has discussed IQN perceptions concerning patient safety in the context of the culture of nursing in which this understanding was constructed. Section 2 will begin the discussion on the impact that the experience of the CAP course and introduction to the NCNZ competencies had on the IQNs' perceptions of the competencies that pertain to patient safety.

## **Section 2: IQN experiences of nursing in the NZ context**

This section discusses the participants' experiences of being introduced to the role of the registered nurse in the NZ health system through the CAP course. The clinical placements that the IQNs were placed in were viewed as CoPs. According to CoP theory, if the defining characteristics of a CoP are present (joint enterprise, mutual engagement and, shared repertoire), then learning and identity formation should occur (Wenger, 1998). Using these concepts, evidence of understanding and

application of the NCNZ competencies during the period of the CAP course is investigated and discussed.

### **CAP course and clinical placement**

Each participant worked in a clinical placement for five weeks. While on clinical placement, IQNs were working with preceptors. Two of the participants were placed in operating theatres (different ones), which was where they had worked in the Philippines, and the other two in Aged Care facilities, which was not where they had worked in the Philippines. The difference between these environments and prior clinical experience is reflected in the data.

#### ***Mutual engagement***

Teamwork appeared to be a feature in the data of the participants in the operating theatres. Both participants saw clear differences in the nurse's role and responsibilities in NZ, articulating that nurses in theatre had clearly defined roles that enabled them to work together to ensure patient safety. They both enjoyed an environment where the multidisciplinary team worked together for the benefit of the patient. The participants in aged care did not mention teamwork. This may partly be due to the structure of aged care facilities in which there may only be one registered nurse on a shift.

As CAP students, the participants in theatre discussed how they felt accepted and had a voice that was encouraged to be expressed and respected. One in particular expressed a sense of belonging and inclusiveness that encouraged him to learn and adapt to the new environment. Literature on interaction in a CoP highlighted acceptance, respect, and participation of the learner in practice as conducive to and enhancing learning (Davis, 2006; Ranse & Grealish, 2007; Hägg-Martinell & Kiessling, 2015; Thrysoe et al., 2012).

Another feature highlighted in the literature concerning CoPs is the reciprocal learning process of a new member's presence in the CoP. This speaks of a new member adding value to a CoP by bringing a fresh perspective (Moule, 2006; Ranse & Grealish, 2007; Sayer, 2014). This was reflected in one participant's account of being asked for his opinion in multidisciplinary meetings. Another participant relayed trying to think of solutions to the format of medication administration in an aged care facility because he saw it as a potential risk to patient safety.

### ***Joint enterprise***

During their clinical placement the two participants in theatre relayed how the nurses were very focused on the patient, catering to their needs in a holistic fashion. They both began to see the value of consistent communication with patients. Similarly, IQNs in Canada were able to see a different approach (from their country of origin) to patient care through a process of interaction and discussion with staff and patients in the clinical environment (Peisachovich, 2015). The older, more experienced participant in this study focused on leadership and how it was expected from nurses at all levels in NZ practice. She saw how the role of the nurse in NZ was very autonomous and multifaceted. IQNs in Lin (2014) also noted the complexity of the role of nurses in the United States that required a high level of autonomy and independent decision-making skills.

### ***Shared repertoire***

The CAP course documents that were analysed during this study relate to the shared repertoire of nursing in NZ. The course outline and timetables clearly and repeatedly directed the CAP students to the tools that define nursing competence in NZ. Despite this, it was only when these were explained and modelled in one participant's clinical placement that he reported starting to understand. This was reflected in Peisachovich (2015) as IQNs expressed how they were not able to transfer the information taught in the classroom until they saw it in practice.

## **Mutual engagement, joint enterprise, and shared repertoire working together**

Only one participant's data clearly reflected the three characteristics of a CoP working together to enhance identity formation. His relationship with his preceptor appeared to facilitate this. This preceptor was described as firstly developing a good relationship with him to make him feel accepted, valued and respected. She then discussed the NCNZ competencies and role modelled how these were enacted in practice. This enabled the participant to begin to understand the role of the nurse in NZ and link theory to practice. He commented that he was becoming a better nurse because he was talking to the patient more and saw this as an important aspect of nursing practice in NZ. This highlights the importance and effectiveness of preceptors articulating and emulating practice as it should be in a CoP (Allan, 2010;

Sayer, 2014; Thrysoe et al., 2012). Furthermore, literature on IQN transition also reports the necessity for well trained and supported preceptors (Allan, 2010; Njie-Mokonya & Josephine, 2014; Riden et al., 2014; Stankiewicz & O'Connor, 2014).

Out of the four participants, only one participant described an effective preceptor. It is not to say that the other IQNs did not have this experience but it was not represented in the data. Despite this, there was some evidence of the beginning of transition and identity formation observed in the data from all four participants as they highlighted differences in the role of the nurse in NZ and the beginnings of adaptation to that role. This evidence of transition is where the impact of the exposure to the NCNZ competencies on the IQNs' nursing practice can be observed. However, this study was investigating if this exposure had an impact specifically on IQN perceptions of the competencies that pertain to patient safety and as such, the data did not reveal any impact on IQNs' perceptions of competencies relating to safety. This is discussed further in section three.

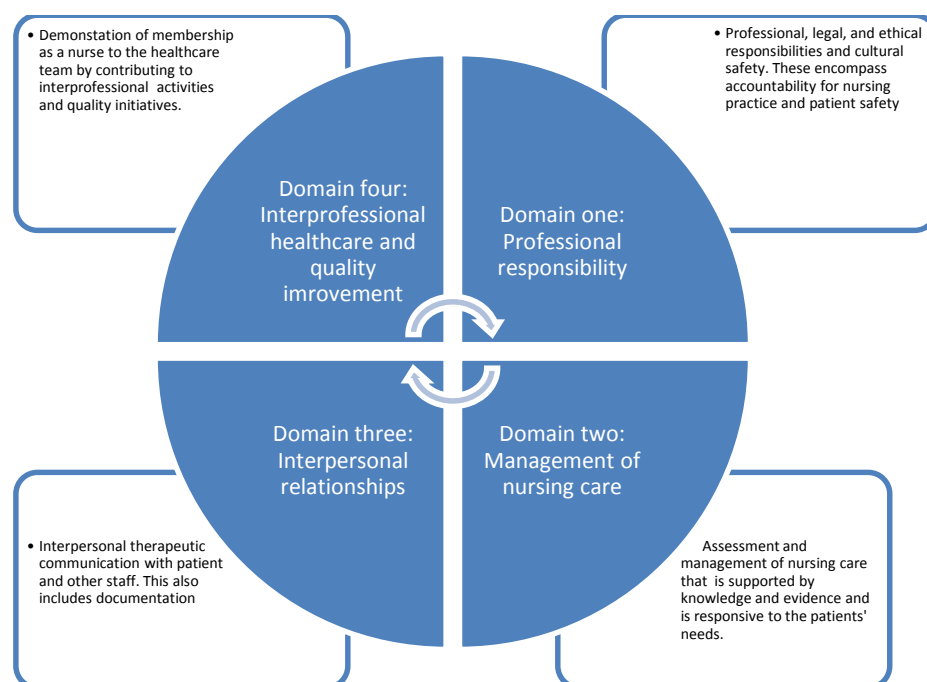
### **Section three: IQN perceptions of patient safety before and after the CAP course**

This section begins by providing a summary of the NCNZ competencies required for safe nursing practice, while also providing a summary of the IQN perceptions concerning the competencies required for safe nursing practice. Similarities and differences between the NCNZ competencies and IQN perceptions will then be outlined, finishing with a discussion of these findings.

#### **NCNZ competencies for safe nursing practice**

The role of the registered nurse in New Zealand requires utilisation of complex clinical judgement skills that incorporates both independent and collaborative practice. Skills necessary to enable partnership with patients and their whānau in order to effectively manage their care are also required (NCNZ, 2016). These skills and others are incorporated into the NCNZ competencies that registered nurses must demonstrate for safe nursing practice. These competencies were introduced to the IQNs during the process of the CAP course. A summary is provided in diagram 1.





**Diagram 1: Summary of NZNC competencies**

## IQN competencies for safe nursing practice

After exposure to the NCNZ competencies through the CAP course, participants reported that overall their perceptions concerning the competencies required for patient safety were the same. As with data from the first interview, significantly more insight was gained concerning these perceptions when asking the IQNs to describe nursing practice experiences in the NZ clinical setting. Table 5 provides a summary.

**Table 5: Summary of IQN perceptions of safety at the beginning and end of CAP**

Participants' perceptions of competencies pertaining to patient safety at beginning of CAP	Additional aspects of patient safety evident in description of nursing care in the Philippines
<ul style="list-style-type: none"> <li>• Patient safety is the number one priority of nursing</li> <li>• Monitoring and maintaining the environment to ensure safety</li> <li>• Asking questions when you don't know</li> <li>• Having rationale for decision making</li> <li>• Health education for patients</li> <li>• Documentation of essential patient information</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment of patients</li> <li>• Priorities of urgency in patient care</li> <li>• Communication with patients and other staff members</li> <li>• Problem solving to manage complex situations</li> </ul>
Participants' perceptions of competencies pertaining to patient safety at the end of CAP	Additional aspects of patient care in NZ noted by IQNs but not linked to patient safety
<ul style="list-style-type: none"> <li>• Patient safety is number one priority of nursing</li> <li>• More staff to cater to patient care in NZ</li> <li>• Readily available equipment available</li> <li>• Rigorous policies and procedures to adhere to</li> <li>• Regular monitoring of staff adherence to these policies and procedures</li> </ul>	<ul style="list-style-type: none"> <li>• Teamwork and mutual respect</li> <li>• Interprofessional collaboration and communication</li> <li>• Consistent communication with patients</li> <li>• Accountability to patients</li> </ul>

## **IQN perceptions of patient safety and the NCNZ competencies**

Van Kleef and Werquin (2012) recommend that during the IQN transition process there needs to be a mechanism through which similarities, differences and gaps in IQN nursing practice are identified in order to highlight where support is required. Therefore, participant perceptions concerning patient safety are examined for similarities and differences to the NCNZ competencies.

### ***Similarities***

When combining the participants' perceptions of patient safety before and after exposure to the NCNZ competencies (represented in Table 5), many of the competencies summarised in the NCNZ domains of competence are reflected in the participant data. However, not all the participants articulated all the elements present in Table 5. Furthermore, the additional aspects that were seen by the IQNs as part of the nursing role in NZ were not attributed to competencies required for safe nursing practice.

### ***Differences***

The role of the nurse in NZ is complex, requiring teamwork, interprofessional communication and collaboration, a partnership relationship with patients, assertiveness, patient advocacy, leadership, and accountability. These are just some of the attributes considered vital for safe nursing practice that appear in the four domains of competence (NCNZ, 2016). These particular attributes, although some of them were observed by the IQNs while on clinical placement, did not appear to be viewed as competencies relating to or linked to patient safety. These differences between the IQNs' perceptions of safety and the NCNZ competencies may arise from the social, cultural, and historical differences in the context of healthcare and the nurse's role in the Philippines. These particular attributes were not apparent in the IQNs' descriptions of the nurses' role in the Philippines. Van Kleef and Werquin (2012) reported that the adjustment process of entering a new health system is a process of making sense of practice without a shared social, cultural, and historical context. This would suggest that the linking and then application of certain competencies pertaining to patient safety is not a straightforward process.

In the literature review concerning IQN transition, communication was highlighted as a significant issue in relation to patient safety (Xu et al., 2012). The communication issue was broken into two aspects, that of the language barrier and intercultural communication, and context. In some measure, all four participants had concerns about their level of skill in English speaking; however, three out of four of the participants did not relate this as an issue once on clinical placement. Although communication is not specifically a feature of the discussion in this chapter, the findings are pervaded with the challenges of communication that relate to the social, cultural, and historical contexts of the participants and thus relate to, and support the literature concerning the intercultural communication challenges faced by IQNs.

### ***The challenge of transition***

The participants in this study had differing ranges of experience and were all highly motivated, articulate and skilled individuals who clearly had patient safety as the priority of their nursing care. However, the constraints and context of their role as nurses in the Philippines posed a significant challenge for transitioning into NZ nursing practice. The four participants expressed the challenge of transition after the experience of their clinical placements. IQNs in Lin (2014) believed they needed a period of at least a year to transition successfully and in Ho's (2015) and Njie-Mokonya and Josephine's (2014) studies, a period of two to three years. Okougha and Tilki (2010) reported that the IQNs in the transition process need ongoing understanding and support over extensive periods of time.

Van Kleef and Werquin (2012) discuss Beach's (2003) consequential transition theory as a useful way to help understand and assist with the difficulties of the transition process. This situated perspective posits that learning occurs and is consequential when the learner is engaged in the process and consciously reflects upon situations. This process can result in changes to perspective of themselves and their social positioning. Considering the context of the nurse's role in the Philippines, this would appear to be a useful concept to consider.

CoP theory, likewise, upholds the importance of reflection in the learning process, and reflection is also considered an integral part of learning in nursing practice and vital to patient safety (Nielsen, Stragnell, & Jester, 2007). Reflection is referred to specifically in Domain one of the NCNZ competencies in relation to

cultural safety and in Domain two; management of nursing care (NCNZ, 2016). Highlighted in these competencies is the need to reflect on one's own values and beliefs, one's own level of competency, and the ability to evaluate and reflect on nursing care. Furthermore, reflection is a vital part of Tanner's (2006) clinical judgement model that is widely valued and used in nursing. The model is based on the premise that a nurses' sociocultural context influences their process of clinical judgement and that a constant reflective process is a vital component for developing clinical judgement and safe nursing practice (Nielsen et al., 2007). It was interesting that through the process of this research, the IQNs' participation involved reflecting on their experiences, both past and present, as they interacted with me as the researcher. This in itself may have impacted their identity transformation in some way. Implications of the value of reflection in IQN transition will be discussed in Chapter six.

## **Conclusion**

The themes that emerged across the four cases in this study have been analysed in light of CoP theory and compared and contrasted with current literature on IQN transition. As IQNs' perceptions of the competencies concerning patient safety were examined within the context of social, cultural and historical influences and the experience of the CAP course, interesting insights emerged. The most significant finding of this study was that the social, cultural, and historical context of the health system and nursing role (that is, the competencies required for safe nursing practice) mediates how maintaining patient safety will be perceived and enacted in practice. These findings suggest that given the social, cultural, and historical context of the participants' roles in nursing, making sense of and application of the competencies that relate to patient safety in NZ is a challenging task and does therefore have implications for patient safety. This also highlights the importance of engaging with participant perspectives in order to identify specific areas required for learning and transfer of information. The implications of these findings will be discussed in the conclusion chapter.

## **Chapter Six: Conclusion**

### **Introduction**

Literature in this study has reported that the challenges involved with IQN transition have implications for patient safety. This study used data gathered from four IQNs undertaking a CAP course to gain insight into their perceptions of the competencies that pertain to patient safety. Exploring these perceptions, and ascertaining whether introduction to NCNZ competencies through a CAP course had any impact on these perceptions suggested directions for educational and healthcare support for IQN transition. The in depth analysis of the four cases with individual interviews, email reflections and CAP course documents has added some useful insights to the slowly growing and much needed body of research that seeks to know how best to support IQN transition. This final chapter centres on the implications that the findings have for educational and healthcare support for IQN transition, and therefore patient safety. Limitations and recommendations are also discussed in this chapter with a final concluding statement.

### **Implications**

This study has three overall implications that are discussed: For the educational support provided for the IQNs, for the healthcare agency support provided for the IQNs and recommendations for further research in this area.

#### ***Educational support***

The first thing to consider is the time deemed adequate for a CAP course. In the short time the CAP course operated, the four participants showed some evidence of transition or identity formation in the NZ CoP of nursing, but both the findings and literature suggest that they would benefit from ongoing support, professional development, and regular reflection. The underlying purpose of the CAP course in NZ is primarily for assessment purposes and therefore not transition support as such. However, as CAP courses are the only link between previous nursing practice and nursing practice in NZ, further transition support may be worth considering. There is a vast spectrum internationally for CAP course equivalents varying from several weeks in NZ to up to three years as is the case in Canada. It would seem that in Canada the

three-year time frame was a deterrent for IQNs; however, a seven-week course may not be long enough. Further research is recommended as to what constitutes an appropriate time frame for CAP courses.

The link between certain NCNZ competencies and patient safety was not apparent in IQN data. The social, cultural, and historical context of the IQNs' health system provided some context for these findings. Incorporation of IQN training that explicitly links the NCNZ competencies to safe nursing practice would appear vital. Scenario training and the use of simulation as seen in the IQN transition literature was reported as an extremely effective way to enable IQN reflection and learning. This could be a particular focus in CAP course content and in ongoing professional development in healthcare agencies.

Other possible supports highlighted in the literature in this study are forums for online support, knowledge sharing, and reflection. It could be considered that for a determined period of time after a CAP course, IQNs meet together in an online forum at regular intervals, for ongoing support and reflection on practice. This supports consequential transition theory which highly values regular reflection as a way in which transition occurs. Reflective practice also, as already discussed, is inherently part of nursing and vital for developing clinical judgement and safe nursing practice. These forums could possibly be facilitated by CAP providers with required IQN participation.

### ***Healthcare agency support***

In the participant data there was clear evidence of the CoP concepts of mutual engagement, joint enterprise, and shared repertoire in the clinical placements. However, there was only one clear example of preceptorship that supported the beginnings of transition by being able to articulate and emulate NCNZ competencies in practice. This highlights the necessity for well-trained and supported IQN preceptors. Currently, the national framework for preceptor training recognises the unique challenges for IQN preceptors but does not offer specific training. As IQNs make up 25% of the nursing workforce in NZ, then specific training appears warranted. NZ literature on IQN transition suggests that organisational and national registers for preceptors would encourage organisational accountability (Riden et al., 2014).

Evidence of the facilitation of learning and transition of IQNs within the CoP theoretical framework was seen in the IQN data in this study. It was also seen to be effective in the literature concerning CoPs and healthcare. Uptake of the collaboration

between education and healthcare to develop learning focused clinical placement areas based on the CoP framework would appear to be worth pursuing.

### ***Further research***

Through the course of this research process, several areas for further research were identified.

The literature review in this study suggested that CoP theory can reveal the situated learning of healthcare professionals. However, although CoP theory highlighted the importance of the social, cultural, and historical context of the participants in the learning and transition process, further research, using consequential transition theory (as described in chapter five) would be useful. Understanding and application of this in CAP courses and preceptor training could prove effective in supporting transition.

Hierarchical structure and power relationships were a prominent theme in the findings of this study. This had several implications for the way the IQNs practised nursing. Although, in this study the IQNs could clearly see the difference in the NZ culture of nursing, this does not guarantee that they would be able to manifest change in their own practice. In CoP theory the concept of power relationships is only discussed in terms of having the power to define competence within the CoP. For example, the NCNZ has the power to define competence for nurses in accordance with the four domains of competence. In an article that reports on an interview with Wenger, he emphasised that CoP is not a theory of power relationships in itself (Farnsworth et al., 2016) and therefore had limitations for analysis of the hierarchical structure reported in this research. Given the data in this thesis, further research into the impact of power relationships using an appropriate theory or theories is also recommended.

### **Limitations**

A potential limitation of this study was that the sample is not representative of the wider IQN population transitioning to NZ via a CAP course. Rich description and quotes have been used to assist with evaluations of transferability. Although all CAP courses are regularly audited and approved by NCNZ, which provides a national benchmark, the content and processes may be varied. The CAP course in this study was a seven-week course with multiple assessments in which the IQNs had to demonstrate their

ability to work as registered nurses in NZ. The added pressure of cultural shyness and language barriers made it difficult to find participants and may have led to the more confident and experienced IQNs volunteering to participate. The participants were also all from the Philippines, providing a particular perspective.

A further limitation was that, although the impact of exposure to NCNZ competencies through the CAP course was a secondary focus of the study, the limited timeframe of the CAP course provided little room to examine this change process.

A further potential limitation for this study was that my own personal knowledge and experience with IQNs may have added bias. This was mitigated in several ways as outlined in chapter three but cannot be excluded as a possible limitation. Finally, the fact that I worked in same tertiary institution as the CAP course may have been perceived by participants as a power relationship in some way despite reassurance. This may have had an effect on the information shared.

### **Personal summary statement**

At the heart of nursing care is patient safety. Everything we learn as nurses and everything we do as nurses is focused on maintaining patient safety and providing holistic care. This is my belief and experience as a nurse, and therefore patient safety was the inspiration for this study. Adequate and consistent support for IQN transition would appear to be key for enhancing safe nursing practice. This final statement summarises the main (in my view as the researcher) insights provided through this research. IQNs need to be accepted and valued members of the nursing workforce who are acknowledged for bringing fresh perspectives to the New Zealand healthcare system, while in the process of learning themselves. In order to transition successfully and practise safely, they need to be self-motivated and open to change while being well supported by specifically trained preceptors and work environments that value and promote mutual engagement, joint enterprise, and shared repertoire. Ongoing support and reflective practice is imperative in this process.



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## **Appendix A: Sample Email to IQN participants prior to CAP programme**

Project title: "Internationally qualified nurses' perceptions of core nursing concepts: Case studies"

Hi (name)

My name is Annie Kane and I am a Nursing tutor, teaching in the Bachelor of Nursing programme at ..... I am aware that you will be attending the May Competency Assessment Programme (CAP) here at..... I will be undertaking a research project during this programme and you will be meeting me on the first day of your course. I will be inviting internationally qualified nurses such as yourself to participate in this research. Your participation would involve two interviews with me, where we would discuss your perceptions around core nursing concepts at the beginning and end of the CAP course. You will also get two emails from asking how you are going on the course. You will be under no obligation to participate in this research and it will not affect your participation in the course.

The research is concerned with the many challenges faced when coming into an entirely new culture and health system. It is recognised that sociocultural differences and a different educational and health background will have an impact on how core nursing concepts are perceived. The purpose of this research project is to explore these perceptions with internationally qualified nurses currently in a CAP programme. It is hoped that the findings from this project will help shape and support the structure that we as educators provide for internationally qualified nurses transition process. This project has ethics approval from ..... and the chair of the Victoria University's Human Ethics Committee.

I look forward to meeting you on the course and explaining more about this project.

Kind regards

Annie Kane



## **Appendix B: Appendix B Research information sheet for participants**

Project title: "Internationally qualified nurses' perceptions of core nursing concepts: Case studies"

Thank you for your interest in this research project. This information is provided so that you can make an informed decision about participating in this study.

This project is being undertaken by Annie Kane and has been approved by the .... and by the chair of Victoria University of Wellington Human Ethics committee.

### **What is the purpose of the project?**

A large number of internationally qualified nurses are coming to NZ to work and attending programmes such as the CAP programme here in ..... We know there are many challenges to face when coming into an entirely new culture and health system. It is recognised that sociocultural differences and a different educational and health background will have an impact on how core nursing concepts are perceived. The purpose of this research project is to explore these perceptions with internationally qualified nurses currently in a CAP programme. It is hoped that the findings from this project will help shape the support structure we as educators provide for internationally qualified nurses transition process.

### **What type of participant are we looking for?**

People with

- Attending a CAP course
- English as an additional language
- Living in NZ five years or less

### **What are the possible benefits and risks of participation?**

There are no risks associated with participation in this study. Being part of the study will not affect any study outcomes. The benefits will be contributing to research aimed at shaping educational support structure for internationally qualified nurses.

### **What will participants be asked to do?**

Take part in two interviews which will be no more than an hour each. These will take place on campus for your convenience in week one and five of the CAP course. You will also be sent by email a transcription of your interview to check and a summary of that transcription. You will be invited to respond to an email invitation to tell me how you are going twice during the course.

### **Can participants change their mind and withdraw from the project?**

You can withdraw from the project at any time up until the middle of June when data analysis will take place. No reason is needed if you choose to withdraw. There will be no disadvantages to you of any kind, or any consequences.

**What information will be collected and what use will be made of it?**

The data will be collected by the recorded interviews on.... campus. These interviews will be transcribed and analysed thematically. The email reflections will also be used for data. The data will be stored safely and securely with password protection for electronic devices and any hard copies will be locked in a drawer. All data will be destroyed after five years.

**Will the information remain confidential and anonymous, and how will this be done?**

All information will be kept strictly confidential within the research team and no names will be used. When the results are published you will not be personally identified. You will be asked to choose a pseudonym for yourself. Any information provided by you can be viewed at any time.

**Is there a cost of taking part?**

It will not cost you anything to take part in this study.

**What if I want more information?**

If you have any questions about this project, at any time, you can contact: Investigator Annie Kane at .....and/or Thesis Supervisor Dr Carolyn Tait on [carolyn.tait@vuw.ac.nz](mailto:carolyn.tait@vuw.ac.nz) or phone 04 4639590.

## Appendix C: Consent form for participants

Project title: "Internationally qualified nurses' perceptions of core nursing concepts: Case studies"

### CONSENT FORM FOR PARTICIPANTS

I have read the Information Sheet about this research project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

This project has been reviewed and approved by ..... Ethics and Research Committee and the Chair of the Victoria University of Wellington Human Ethics committee

I understand that:

1. My participation in the project is voluntary and will have no impact on my course of study;
2. My identity will be kept confidential and a pseudonym will be used;
3. I am free to withdraw from the study up to the point when I am advised the data are to be analysed. I can withdraw the information provided, without any consequence;
4. I consent to participating in the interview process and being audio recorded;
5. I also consent to responding to two emails from the researcher. The responses will be used as data;
6. The audiotapes will be destroyed at the end of the project but any raw data on which the results of the project depend will be kept in secure storage for five years, after which it will be destroyed;
7. If I experience any emotional discomfort due to the nature of the topic, while participating in this research the researchers will provide assistance and/or refer me for assistance;
8. I will not be paid for my involvement in this project;
9. The results of the project may be published but my anonymity will be maintained, and any personal information will remain confidential.

I agree to participate in the procedures.

I consent to participating in this project.

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(Signature of participant)

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(Name)

(Date)

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(Signature of Researcher)

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(Name)

(Date)

Any concerns can be directed to the Research Manager, at ..... and/or Victoria University HEC Convener: Associate Professor Susan Corbett. Email [susan.corbett@vuw.ac.nz](mailto:susan.corbett@vuw.ac.nz) or (04 463 5480)

I would like to receive a brief written summary of the project.

Yes/No

My email address for this is.....

## Appendix D: Interview questions and prompts for IQN reflections

Project title: "Internationally qualified nurses' perceptions of core nursing concepts: Case studies"

**Interview Questions for IQNs** The guiding questions for these interviews are:

### Initial interview

1. Tell me about yourself. (Demographic data will be sought such as experience, culture, professional background, professional education, gender and life experience).
2. Tell me about the competencies/skills you developed as part of your training to become a registered nurse and through your practice in X country?
3. What does patient/health consumer safety mean to you?

Sub questions:

- a) What are some of the values, attributes and skills you would need to ensure patient safety in NZ?
- b) Can you describe a situation where you had to act to ensure patient safety? Do not use names or identifying features of people or places. This can be an imaginary situation.
- c) What do you think will be the biggest challenge for you practicing nursing in NZ?

### Final interview

1. How do the competencies from your previous training compare with the NZ competencies that you have been introduced to in the CAP course?

Sub questions:

- a) What does the phrase "patient/health consumer safety mean to you as a nurse in NZ
- b) What are some of the attributes, skills and values you would need to ensure patient safety in the NZ nursing context?
- c) What do you think will be the biggest challenge for practicing in NZ? Why do you think this?

Prompts for reflection:

These prompts will be sent in an email to the participants so they can reply as briefly as they wish.

1. How is the introduction to nursing in NZ going for you?
2. What are the challenges and successes that you have experienced?