Factors affecting the integration of immigrant nurses into the nursing workforce: a double hermeneutic study

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Abstract

Background: Variations in nursing practice and communication difficulties pose a challenge for the successful integration into the workforce of immigrant nurses. Evidence for this is found in cultural clashes, interpersonal conflicts, communication problems, prejudiced attitudes and discrimination towards immigrant nurses. While the evidence shows that integrating immigrant nurses into the nursing workforce is shaped by factors that are socially constructed, studies that examine social structures affecting workforce integration are sparse.

Objectives: The aim of this study was to examine interplaying relationships between social structures and nurses’ actions that either enabled or inhibited workforce integration in hospital settings.

Design: Giddens’ Structuration Theory with double hermeneutic methodology was used to interpret 24 immigrant and 20 senior nurses’ perceptions of factors affecting workforce integration.

Results: Four themes were identified from the data. These were: 1) employer-sponsored visa as a constraint on adaptation, 2) two-way learning and adaptation in multicultural teams, 3) unacknowledged experiences and expertise as barriers to integration, and 4) unquestioned sub-group norms as barriers for group cohesion. The themes presented a critical perspective that unsuitable social structures (policies and resources) constrained nurses’ performance in
workforce integration in the context of nurse immigration. The direction of structural changes needed to improve workforce integration is illustrated throughout the discussions of policies and resources required for workforce integration at national and organisational levels, conditions for positive group interactions and group cohesion in organisations.

**Conclusion:** Our study reveals inadequate rules and resources used to recruit, classify and utilise immigrant nurses at national and healthcare organisational levels can become structural constraints on their adaptation to professional nursing practice and integration into the workforce in a host country. Learning from each other in multicultural teams and positive intergroup interaction in promoting intercultural understanding are enablers contributing to immigrant nurses' adaptation and workforce integration.

**Key words:** Cultural diversity, Health care organisations, Double hermeneutic, Hospital nursing staff, Immigrant nurses, Nursing administration research, overseas-educated nurses

**What is already known about the topic?**

- There is evidence that Immigrant nurses from non-white racial groups experience discrimination that negatively impacts on workforce integration.
- Workforce integration is impeded by the fact that many immigrant nurses from non-English speaking backgrounds experience communication problems with their colleagues and patients.
- Immigrant nurses face significant challenges in adapting their practice to the host country due to variations in nursing practice.
What this paper adds?

- Employer-sponsored visas used to increase the recruitment of overseas nurses can contribute to discrimination towards immigrant nurses if there are no adequate resources to protect their rights and support their adaptation.
- Inadequate regulatory policies used to classify immigrant nurses’ expertise and experiences can contribute to institutional discrimination towards immigrant nurses.
- The need for immigrant and host nurses to learn from each other is demonstrated in everyday practice in multicultural teams, but has not been acknowledged as a condition for workforce integration.
- Unquestioned group norms in the workplace due to lack of multicultural education contribute to group alienation and impact on group cohesion.
1. Background

Australia has a multicultural population with approximately 44% either born overseas or with a parent born overseas (Australian Department of Immigration and Citizenship (ADIC), 2011). This is evident in the labor force, particularly nursing. The Australian nursing workforce has become even more multicultural in the last decade partially due to the use of immigrant nurses to fill health care vacancies (Australian Institute of Health and Welfare (AIHW), 2009). The 2007 annual nursing workforce survey indicates that approximately 15.5% nurses were trained outside of Australia (AIHW, 2009). Notably, the donor countries of these nurses have shifted from mainly English speaking to non-English speaking nations (Australian Bureau of Statistics (ABS), 2007, AIHW, 2009). Although nursing practice shares many similarities across countries, it is also socially, culturally and politically constructed. Variations in nursing practice along with communication difficulties are challenges for the host country to overcome in facilitating successful workforce integration. In this study the definition of nursing workforce integration is amended from Berry’s concept of “Cultural Integration” (Berry, 2003, p. 24) to immigrant nurses interact with host nurses to adapt their professional practice in a host country and the process of adaptation is reciprocal for both groups of nurses.

1.1. Issues of concern in workforce integration

The demand for immigrant nurses in Australia is driven by three major factors: population growth, the ageing population, and the burden of disease (AIHW, 2009). It is estimated that Australia’s population will increase from 20.6 million in 2006 to 30.6 million by 2051 (ABS, 2007). The proportion of people aged over 65 years is expected to increase steadily from 14% in 2010 to 29% in 2050 (Productivity Commission, 2011). Between 1990 and 2005 the
number of people living with a chronic condition increased from 69.6% to 78.4% in the female population and from 66.6% to 75% in the male population (National Health Workforce Taskforce, 2009). However, “the ratio of nurses to total population in Australian dropped from 10.8 per 1,000 population in 1986 to 9.8 in 2001” (ABS, 2005, p. 102). The shortfall in nurses is being primarily addressed through international immigration. Since 2002, there has been a significant increase in the number of immigrant nurses from non-English speaking counties applying to work in Australia (ADIC, 2009, AIHW, 2009).

Registration standards for internationally educated nurses in Australia share many similarities with those in other English-speaking countries as outlined in Table 1 (College of Registered Nurses of British Columbia, 2013, Commission on Graduates for Foreign Nursing Schools, 2013, Nursing & Midwifery Council, 2013, Nursing and Midwifery Board Australia (NMBA), 2011, Nursing Council of New Zealand, 2013). International recruitment of nurses is supported by the Australian Government’s “Skilled Migration” and “Employer Nomination” visa schemes (ADIC, 2011). To be eligible to apply for one of these visas, nurses must meet the registration standards and the points test as an independent applicant or gain sponsorship from an eligible employer (ADIC, 2011). Nurses from seven recognised English-speaking countries (see Table 1) are exempted from the English proficiency test (NMBA, 2011). They are named as nurses from an English speaking background (ESB) while the others are called nurses from a non-English speaking background (NESB).

[Insert Table 1 here]

It is widely recognised that immigrant nurses’ adaptation to nursing practice in a host country
is a key variable affecting workforce integration. The first year of employment is the most difficult period for those from a NESB as they experience multiple challenges in dealing with cultural shock, conflict resolution and intercultural communication while adapting their nursing knowledge and practice to the host culture (Xu, 2007, Yi and Jezewski, 2000). Most NESB nurses come from developing countries that espouse collectivist cultural values that prize group achievements over individual ones (Ting-Toomey, 2010, Xu, 2007, Xu and Davidhizar, 2004). Most host countries who employ these immigrant nurses endorse individualist cultural values that encourage individual achievement and independence (Xu, 2007, Xu and Davidhizar, 2004). Cultural clashes with patients and colleagues are widely reported (Omeri and Atkins, 2002, Xu et al., 2008, Zhou et al., 2011). For many of these nurses it takes 5 to 10 years to achieve an ideal level of acculturation (Adams and Kennedy, 2006, Xu, 2007, Yi and Jezewski, 2000). Ea and colleagues (2008) identified that a level of acculturation is positively associated with job satisfaction for immigrant nurses and benefits long-term integration into the nursing workforce.

Interactions between immigrant nurses and host nurses also influence workforce integration. Positive interactions are conditioned by intercultural understanding and egalitarianism principles (Allan et al., 2004, Gay, 1995, Ting-Toomey, 2010). Research identifies that these conditions are difficult to achieve due to the lack of knowledge of each other’s cultures, the existence of ethnocentrism and racial discrimination (Allan et al., 2004, Dreachslin et al., 2004, Pololi et al., 2010). Immigrant nurses are expected to expend considerable effort in assimilating into the healthcare system, while little is demanded of host nurses (Alexis and Vydelingum, 2004, Xu et al., 2008, Yi and Jezewski, 2000).
There is an argument that host nurses can learn from immigrant nurses in order to accommodate, negotiate and restructure practices in the best interest of patients (Alexis and Vydelingum, 2004, Hubbert, 2006, Jose, 2011). Cultural imposition, a form of domination, occurs when immigrant nurses are expected to adapt to nursing practice without any consideration or sensitivity towards their values and beliefs. It can result in a devaluing of their previous experiences and expertise (Alexis and Vydelingum, 2004, Allan et al., 2004, Jose, 2011). Education and support that incorporates principles of cultural pluralism, equality and inclusion can mitigate against cultural imposition (Banks, 1995, Gay, 1995). The success of any education program or instruction in a cross-cultural context largely relies on the application of critical pedagogy characterised by challenging unquestioned assumptions, critical reflection on cultural issues, valuing the perspectives of silent groups and bringing changes via empowerment (Banks, 1995, Gay, 1995).

Intercultural understanding is also significantly affected by a lack of knowledge and skills necessary in intercultural communication (Ting-Toomey, 2010, Xu and Davidhizar, 2004). Language barriers, lack of familiarity with each other’s communication styles both verbally and nonverbally, and with connotative and denotative meanings of words used in a particular cultural context, contribute to a failure to reach intercultural understanding (DeSouza, 2008, Ting-Toomey, 2010, Xu and Davidhizar, 2004). The complexity underlying intercultural understanding suggests that both immigrant and host nurses need to develop ‘cultural intelligence’ that comprises metacognitive (cultural theory), cognitive (cultural facts), motivational and behavioural dimensions via education, practice and critical reflection (Ang
Sub-cultures formed by different groups prevail in organisations even in countries with a homogeneous population (Turner, 1987). Immigrant nurses add additional various sub-cultures to healthcare organisations in the host country because they come from a number of different countries. Self-categorisation theory argues that people who share similar social characteristics such as ethnicity, country of origin, religion, and interest tend to develop social attachments and group cohesion while alienating those who differ from them (Turner, 1987). Research has identified that immigrant nurses have difficulties fitting into the mainstream culture (Gerrish and Griffith, 2004, Omeri and Atkins, 2002, Zhou et al., 2011). Leaders in an organisation can take action to mitigate group alienation by engaging them in activities that promote group contact and positive interactions (Dreachslin et al., 2000, Groves and Feyerherm, 2011, Schein, 2010).

1.2. Structuration Theory as a framework guiding this study

While the evidence shows that integrating immigrant nurses into the workforce is shaped by factors that are socially constructed, studies that examine social structures affecting workforce integration are sparse. Giddens’ Structuration Theory provides one avenue for analysing social structures that shape people’s actions, and illustrates changes in ways that are realistic and practical. Social structure, as used by Giddens, refers to the ‘rules and resources’ associated with the exercise of power over people’s actions (Giddens, 1984, p.25). The rules in a society are either formal (legislation and policies) or informal (tactical and cultural norms). Resources are divided into allocative and authoritative resources, with the former concerned with the
material resources (infrastructure) used to control citizens, and the latter dealing with the capability of harnessing human activities (leadership). Social structures and people’s actions (or agency) are not separated as ‘a dualism’, but are ‘a duality’, inseparable and shaped by each other (Giddens, 1984, p.25). Structures enable the channeling of people’s actions in a specific manner, but on the other hand may also constrain people’s rational actions. As a consequence the outcome of peoples’ actions will include both ‘intended’ and ‘unintended consequences’. Conversely, this theory acknowledges that people have the capability, generated from a ‘reflexive form of knowledgeability’ (p.3) to re-develop structures in order to improve practice. Figure 1 below demonstrates the 'duality' relationship via means of human reflexive circles.

[insert Figure 1 here]

The aim of this study was to examine interplaying relationships between social structures and nurses’ actions that either enabled or inhibited workforce integration in hospital settings.

2. Design

This study applied a double hermeneutic approach espoused by Giddens to address the objectives of the study. A double hermeneutic is described by Giddens (1984, p. 374) as “the intersection of two frames of meaning as a logically necessary part of social science, the meaningful social world as constituted by lay actors and the metalanguages invented by social scientists”. This methodology enables the researcher not only to empirically document the actor’s self-described actions and social conditions (interpretive hermeneutic), but also to reveal structural constraints on people’s rationality and autonomy in social practice (critical hermeneutic) using social theories or so-called “metalanguages”. Double hermeneutic is
viewed as critical hermeneutic, a form of critical methodology used to critique structural domination and illustrate ways to reform social structures (Giddens, 1984).

Qualitative and quantitative approaches have been widely used in studying immigrant nurses (International Centre on Nurse Migration, 2013, Xu, 2007, Zhou et al., 2011). Although these approaches have advantages in analysing issues affecting immigrant nurses’ practice, for example, immigrant nurses’ English proficiency, cultures and work environments, they have limitations in capturing the structural constraints on nurses’ performance in workforce integration and in illuminating changes due to a lack of “metalanguages” developed by critical theorists. The double hermeneutic approach underpinned by Gidden's Structuration Theory provides suitable theory and methodology to overcome the limitations in qualitative and quantitative studies. For example it informed us of the interplay in relationships between social structures and nurses’ actions (the aim of study) and directed us to embed critical concepts such as nurses’ actions and rules and resources enabling or constraining their actions, into the semi-structured questions (see “Data collection” and Appendix 1). In addition, the four levels of understanding described in the double hermeneutic enlightened the procedures used to analyse codes, categories and themes in addressing the study aims.

2.1. Settings and participants

This study was conducted in two major general hospitals in an Australian metropolitan city. A purposive sample of nurses that included host and immigrant nurses from those hospitals was selected. The selection criteria included: immigrant nurses from NESB with at least one years work experience, and senior nurses with a supporting or supervision role with immigrant
nurses at ward or organisational level. Two senior nurses who were involved in recruiting immigrant nurses in the two hospitals helped the distribution of letters to potential participants. The letter enclosed a “participant information sheet”, “semi-structured questions for focus group and interview” and a “participant’s response slip”. Nurses who met the selection criteria (listed in the information sheet) and were willing to participate in either a focus groups or interviews were asked to provide their contact details on the “participants response slip” and return it to the first author via a pre-paid and pre-addressed envelope. The researcher contacted participants by email or phone to inform them of the time and venue for the focus group discussions. For those who were unable to attend the focus group or chose to be interviewed, the researcher negotiated the time and venue for interview with them.

2.2. Data collection

Focus groups and face-to-face in-depth interviews with participants were used as the major data collection methods. Data collection was conducted over a 6-month period in 2010. Two sets of semi-structured questions were used for immigrant and senior nurses respectively. The authors developed these questions based on a literature review and their pre-understanding of Structuration Theory. These questions focused on the four areas concerning workforce integration: 1) group interactions, 2) challenges nurses faced and strategies used to cope with these challenges, 3) supports for nurses, and 4) the utilisation of immigrant nurses. The questions also reflected concepts of actions, rules, resources and consequences describe in the Structuration Theory (see Appendix 1).

Both the first and the second author attended the four focus groups with one acting as a
facilitator and the other as the observer. The observer took notes on group dynamics that aided in providing memory prompts during the analysis phase. Each interview was taken by one of the two authors. Focus groups and interviews were conducted in meeting rooms in the two hospitals using participants’ rostered professional development time. Focus groups went for 90 to 120 minutes and interviews last 45 to 60 minutes. Both focus group and interview were audio-recorded and transcribed verbatim for analysis.

2.3. Data analysis

Data analysis and interpretations were informed by Giddens’ four levels of understanding of how social structures enable and inhibit people’s actions (Giddens, 1984, p. 327). The authors modified the description of these levels to suit the context of this study by: 1) identifying participants’ understanding of actions affecting workforce integration, 2) identifying participants’ understanding of the social conditions influencing these actions, 3) analysing unintended consequences and unacknowledged social structures, and 4) identifying social structures that will improve nurses’ performance in workforce integration. The interpretive hermeneutic is achieved via the first and second levels of understanding while the critical hermeneutic is achieved through the third and forth levels of understanding.

The first author undertook preliminary data analysis, circulated findings to the team for crosschecking and discussed findings in regular meetings. Participants’ descriptions that were significant for workforce integration were highlighted in the transcripts and listed in a table for coding under the four areas (see above) and the codes were grouped into “actions” and “conditions” (see examples in Appendix 2). Once the researcher completed the coding for this
selected raw data, comparisons of the codes across focus groups and interviews were made to reduce codes. The final codes were further grouped and summarised based on meanings, and analysed for the authors’ intergradation of group codes into categories. The categories represent nurses’ perspectives of their actions and social conditions affecting workforce integration.

The categories were analysed, grouped and summarised based on meanings. The authors reflected on unintended consequences and articulated how unsuitable or unacknowledged rules and resources contributed to these unintended consequences. Like most critical research projects, the final themes developed highlighted barriers for the purpose of facilitating changes. The direction of changes is illuminated through the presentation and discussion of these themes.

2.3. Study rigor

Rigor was achieved by demonstrating the consistency in the application of Structuration Theory and double hermeneutic analysis in the study (dependability). Rigor was further enhanced by adhering to the hermeneutical circle in which some participants from immigrant nurses were invited to critique findings (credibility). Initially the authors asked immigrant nurses to express their interest in critiquing findings from the focus group or interview. Six indicated their interest, however, only four returned their comments to the researcher. The authors only asked immigrant nurses in this study as this group were the most affected by workforce integration and their agreement with findings largely decided whether recommendations would work for them. Comments were very positive, for example: “The
themes you discussed are true stories in our working place”; “It is a good resource of evidence-based for the hospital managers to think about how to integrate international nurses into the nursing workforce”.

2.4. Ethical considerations

The ethics committee of the University approved this study. Participants were contacted by letters or email to request voluntary participation in either a focus group or interview. Informed consent was obtained before data collection. Guarantees of confidentiality, freedom of refusal to either participate or to withdraw from the study, or to refuse to discuss particular questions was provided to all participants. The data was deidentified and stored in a secure area in the University.

3. Results

Twenty four (24) immigrant nurses from Non-English Speaking Backgrounds and 20 senior nurses participated in this study. The characteristics of participants are outlined in Table 2. Data were collected from three focus groups plus 5 individual interviews with immigrant nurses. The numbers of participants in focus group one, two and three were 9, 5, and 5 respectively. Data were also collected from one focus group with 10 senior nurses plus 10 individual interviews with other 10 senior nurses (see Table 3). Immigrant nurses came from 7 non-English speaking countries with the majority from China and India. All of them immigrated to Australia voluntarily and intended to stay in the country permanently evidenced by their permanent resident status. The majority of senior nurses were Australian. Most immigrant nurses were employed at Registered Nurse (RN) level 1, the first level in a 6-level
RN classification (Australian Nursing Federation (ANF), 2009) and many had more than 10 years nursing experience in their home country prior to coming to Australia, but less than five years in Australia.

The final four themes revealed unintended consequences generated from a recruitment rule (theme one), unacknowledged rules and resources in care teams (theme two), organisation’s rules as barriers (theme three), and unquestioned group norms as barriers (theme four). The four groups of categories from the interpretative hermeneutic that informed the development of the four themes are also listed in Table 4.

3.1. Employer-sponsored visa as a constraint on adaptation

Although an employer-sponsored visa is an efficient solution for employers to quickly resolve the nurse shortages, it may generate unintended consequences. Senior nurses clearly identified that NESB nurses agreed to work in areas outside their expertise in order to gain employer-sponsored visas. As one senior nurse stated:

All they want is a job and a sponsorship. They will work in areas outside their expertise and I can tell you they really struggle in areas outside their expertise... I think they're not prepared. A lot of times when they do the courses at uni [University] they don't get a clinical placement that matches their skills like they
might be an intensive care nurse that’s gone to Disability SA to do their 6 weeks or 8 weeks placements...The unfortunate thing is because they don't have permanent positions they will put up with a lot and I suppose if anything I wish they would follow through on some of the discrimination that happens with them (SN Interview No 5).

The first priority for immigrant nurses is to survive and gain employment. As a consequence they are often more accepting of ‘discrimination’, less likely to be assertive, or critical of their peers, or to take on leadership roles in the care team. These are qualities that are crucial to nursing practice in Australia. In addition, during training they can be placed in venues where there are few staff to help them gain relevant clinical experience in the area they seek employment. The unintended consequences arise out of the fact that there are few resources developed to support employer-sponsored visa candidates.

The matching and mismatching of immigrant nurses’ expertise has a significant impact on their adaptation and interpersonal relationship with host nurses, as two immigrant nurses stated:

I had been working in general medical ward for years in my home country and I feel quite comfortable to work in the same area here. ...It just took a short period time for me to fit in and to prove my ability (INFG3, No 2).

I didn’t have experience in ICU [Intensive Care Unit] in my home country. It was
very traumatic experiences for me in the beginning. I had only 2 supernumerary
shifts in the morning before I started my first shift in the afternoon. ...I worked on
my own in a bay in one-on-one care. I didn’t know the routine in the afternoon
shift and had to ask the nurse next to me. ...some of them are supportive, but some
of them are not. One said to me ‘if you don’t know how to do that [procedure],
how could you get your RN license’(INFG3, No 5).

The unfamiliarity with nursing routine and practice in a new specialty area inevitably puts
additional strain on the immigrant nurses’ adaptation and is a burden for local nurses. Both
groups are less likely to have positive interactions under such conditions and interpersonal
conflict can arise. Where healthcare organisations employ immigrant nurses in areas outside
their expertise without providing adequate support they contribute to the structural
domination that works against their full integration into the nursing workforce.

The lack of resources to support the increased numbers of immigrant nurses was recognised
by senior nurses in one of the hospitals and they made great efforts to initiate an ‘Immigrant
nurses and midwives program’. As a senior nurse described:

   We have established a program for newly employed immigrant nurses and
   midwives. Normally we have a booklet with the information in it. We meet them on
   their induction day and discuss with them the information. ...A nurse educator
   will visit them at least 2 or 3 times a week in a clinical area and will support them
   clinically and culturally out there. ...it's not so much of a clinical focus. It's just
that friendly person that will say hi, how are you going. ...We run weekly what we
call network in-service sessions. ...We'll have expert clinicians or we'll just have a
debriefing time (SN Interview No. 8).

Feedback from immigrant nurses indicated that this initiative gave them useful information
and support at an organisational level in the first 6 months of their employment. However,
they said they also needed mentoring support at ward level to cope with the day-to-day
challenges they faced.

3.2. Two-way learning and adaptation in multicultural teams

Although immigrant nurses are expected to assimilate to the healthcare system in a host
country, our study identified that host nurses also made allowances in order to assist
immigrant nurses to adapt to multicultural teams. Passing an English proficiency test by
NESB nurses does not guarantee communication success in the workplace. Ability in
intercultural communication was acknowledged by NESB nurses as the most challenging
aspect of their work and it took a long time to adapt their own communication style to that of
the host country or to understand all the nuances. Senior nurses identified that they made
particular effort to adapt their behaviours in order to facilitate communication in the
multicultural care team. As a senior RN noted:

I had a nurse ring me the other day, she needed a drug that wasn't on their ward
and I asked her to give me the name of the drug. I couldn't understand what she
said. I asked her to spell the name of the drug for me. I couldn't understand the
Both immigrant nurses and host nurses in our study acknowledged that the multicultural care team put additional stress on both host and immigrant nurses. Host nurses did make allowances in everyday interactions with NESB nurses in the best interest of patient care. However, the need for this was not acknowledged or rewarded, nor is it evident in organisational policies and performance reviews. The lack of formal recognition of host nurses’ contributions to immigrant nurses’ adaptation may be associated with a burden felt by host nurses and an unwillingness to work with NESB nurses.

Reflecting on their experiences in mediating cultural clashes between host and immigrant nurses, senior nurses suggested there was a need to develop resources to educate both host and immigrant nurses about cultural differences:

*We received complaints from Australian nurses that immigrant nurses said ‘yes’ to them, but did not get things done* (SNFG No 1).

*We don't understand that someone looking at us in the eyes doesn't mean that they're lying or not understanding. It might be a cultural thing, for respect, they don't want to be seen to lose face* (SNFG No 2).

These examples reveal that language and communication is culturally-bound, suggesting both
host nurses and immigrant nurses need to learn from each other regarding the different manners, styles and body language used in communication across cultures. Intercultural communication cannot be achieved without taking account of how culture impacts on communication.

Immigrant nurses also identified that adapting their nursing practice to the host country meant unlearning and learning new nursing activities and a new care model, as an immigrant RN focus group reported:

*The RN in my country is only the source of knowledge for the family carers due to extremely low RN-patient ratio. We do not do showering or feeding. Their relatives do or they hire own personal carer to do those for them. Assisting patients’ ADLs [activities of daily living] was a new learning curve for me in the very beginning here (INFG 1 No 1).*

Discussions with senior nurses supported the view that immigrant nurses face significant challenges in exercising autonomy and developing a therapeutic relationship with patients. Integrating into the nursing workforce means adapting to the political and cultural values that underpin healthcare in the host country, as a participant described:

*We Australian nurses have a lot more autonomy, critical thinking, initiative and that also comes from the society we've grown up in. ...It is the culture of Australian that you know I feel empowered to voice my opinion whereas if I work*
While immigrant nurses faced a steep learning curve, resources available for them to ease their adaptation were limited, as a senior nurse stated:

*They do 2 days of corporate orientation and then they have 2 days in the clinical area and then they take a patient load. ...Every ward has a peer support nurse. ...That's for all nurses new to the hospital not just for immigrant nurses* (SNFG No 6).

There is a lack of orientation specific to the immigrant nurses’ need to learn how to adapt. This situation points to a lack of suitable resources in healthcare organisations relevant to the needs of immigrant nurses.

### 3.3. Unacknowledged experiences and expertise as barriers to integration

Our study revealed that the job classification for RNs (ANF, 2009) had been interpreted in various ways by different healthcare organisations when applying it to immigrant nurses and was associated with the breach of fair treatment principles. Immigrant nurses’ previous experiences and expertise were not acknowledged by the employer, as one immigrant RN stated:

*I came with 15 years of experience and they told me they did not consider any of my experience. I was employed as just RN 1 and year 1. Later I found out another*
overseas nurse who worked as a RN 1 year 9 by accident. ...I asked my ward manager why they did in my case. ...Finally they recognised my experience and all overseas nurses' previous experiences in the hospital (INFG 1 No 8).

This case exposes the lack of criteria and equity frameworks for assessing immigrant nurses’ previous experiences. Such practices perpetuate discrimination at the institutional level. In the multicultural nursing workforce, this kind of discriminatory practice inevitably causes conflict between groups and threatens workforce integration. The finding shows that organisational policies and procedures can also generate discrimination that impacts on immigrant nurses. Regular review of the organisations’ policies and procedures to reflect the ever-changing workforce is imperative.

Our study also identified immigrant nurses’ expertise and skills were not acknowledged by the employer, but were acknowledged by their colleagues. Senior nurses recognised immigrant nurses’ strengths and the value they added to the organisation particularly other multicultural populations. As a senior nurse noted:

I believe that they will bring a sense of understanding that Australian nurses don't have in transcultural nursing. ...I think they will give the Australian staff an understanding of why the family is behaving like that or why the patient is requesting that (SN Interview No 5).

These strengths were used in the workplace as an immigrant nurse described:
...I have been contacted sometimes to help other nurses in the unit because my bilingual and bicultural background... An older postoperative patient was very agitated and tried to get out of the bed while he was not haemodynamically stable. He could not speak English... I found he tried to convince the nurses that he wanted to talk to his family... My help reduced the use of sedatives for the patient (INFG 2 No 4).

Although immigrant nurses demonstrated their expertise and were selected to work in specialised areas such as ICU, there is no mechanisms to assess their competency as specialist nurses, a category in the Australian nurses' classification levels (ANF, 2009). Using immigrant nurses as interpreters without formal preparation and recognition as identified in our study may have little positive impact on workforce integration or the development of leadership in immigrant nurses.

Nursing practice in developing countries is often regarded as inferior to that in developed nations. The lack of clear rules and resources to accredit immigrant nurses’ specialist knowledge and skills may be influenced by such an ideology. Establishing clear rules with necessary resources to accredit immigrant nurses’ expertise not only empowers them to fully participate in the reduction of healthcare disparity in a multicultural society, but it is also an efficient strategy for utilising this human resource to deal with fiscal challenges in healthcare.

3.4. Unquestioned sub-group norms as barriers for group cohesion
While immigrant nurses acknowledged that the majority of host nurses were supportive, they also encountered discrimination and cultural impositions, as an immigrant RN described:

*I was employed as an RN 1 year 9. In the very beginning, one nurse said to me in the front of others that I should be in charge of the whole ward in order to be fair enough for other nurses as I got year 9 pay. I told her that I would, but I needed time to be familiar with the work environment. Then she said if you did not feel confident to take year 9 you should start from year 1. ...I had been watched all time and criticised that I shouldn’t do things in the way I was doing (INFG 1 No 4).*

The negative experience described by this immigrant nurse is consistent with what other senior nurses identified, as a senior RN stated:

*I've had them [immigrant nurses] say to me that they would rather start off being paid as an RN year 1 and I say to them you deserve to be paid above that. Sometimes they feel that a pressure because you know on the roster you know the RN year 9's rise to the top. ...Some staff makes it very difficult for that to happen (SNFG No 9).*

These phenomena expose the lack of cultural sensitivity in nurse-nurse intercultural encounters. As a result of these observations one of the hospitals in this study initiated a cultural education program, as a senior nurse stated:
We held a forum where we got a number of immigrant nurses to tell their stories, cultures and practice from their home countries. The main idea of that forum that we had was we just wanted nurses here to get to know immigrant nurses so that they will be able to support them better and be a bit more patient with them. ... They were listening very intensely to these nurses they didn’t know them but when the session was over the host nurses were going up to them shaking their hands and introducing themselves to them (SNFG No 10).

The engagement of both host and immigrant nurses in the forum further supports the two-way approach of learning in multicultural settings. This well-organised activity aimed at improving intergroup understanding and interactions demonstrated leadership, a powerful mitigating factor to cultural discordance in an organisation.

The staff room was identified as an important social space for international nurses to interact and had a strong impact on group cohesion, as an immigrant RN focus group member noted:

[During the break] we normally talk about family, kids, TV shows, sports pets, and holidays. It is a way to improve my English communication, share information and learn rules in the new country (INFG 1 No 1).

We also talk about patients as well or ask each other what you think about your work in the morning yeah... I guess some debrief also can reduce your stress level
These examples indicate that group integration happens through informal conversation based on common areas of interest. These positive interactions in multicultural groups should be encouraged in the workplace as they benefit all. However, our study also identified that this social space can be alienating, as an immigrant nurse focus group members noted:

*It's very common that for nurses who are from the same country speak their own language at break time because we are on different shifts we don't normally see each other so it's also a good opportunity for us to catch up* (INFG 3 No1).

*...one staff complained to me that she felt boring when three of us talked in our language in the staffroom. I recognise that we should be inclusive and engage her in our conversation so we just speak English* (INFG 3 No.2).

This phenomenon is consistent with self-categorisation theory and illustrates the way in which immigrant nurses tend to form sub-groups and sub-cultures in the organisation. Host nurses can be alienated by immigrant nurses in the absence of culture awareness.

**4. Discussion**

The application of Giddens’ Structuration Theory enables us to interpret findings in our study and to identify the direction of structural changes in the field of nurse migration. The four themes identified in our study have elaborated the interplaying relationships between social
structures and nurses’ actions that enabled or inhibited workforce integration. Our study revealed that the rules used to recruit immigrant nurses at a national level have generated unintended consequences due to a lack of resources to protect immigrant nurses’ rights and to support their adaptation. Inadequate institutional rules used to classify immigrant nurses’ expertise and experiences are inconsistent with the anticipated workforce integration and can contribute to institutional discrimination. The need for immigrant nurses and host nurses to learn from each other is demonstrated in everyday practice in multicultural teams, but has not been acknowledged. This is evidenced by the lack of resources to support the learning among team members. Unquestioned group norms manifest themselves in the workplace and contribute to group alienation. Findings in our study have further reinforced Giddens’ Structuration Theory.

The findings of this study confirm previous research that noted that discrimination against immigrant nurses exists in healthcare organisations (Alexis and Vydelingum, 2004, Allan et al., 2004, Omeri and Atkins, 2002). Further, the study identified that the employer-sponsored visa scheme used as part of the national recruitment strategy can generate discrimination if immigrant nurses consent to work outside of their area of expertise and have little transitional support. Such recruitment behaviour violates the human rights of immigrant workers (UNISON, 2006, United Nations, 1990). The covert nature of discrimination through policy implementation suggests that recruitment policies should be coupled with resource development and regular review of the outcomes to minimise structural discrimination.

The findings in our study confirm previous studies that identify that inadequate support for
immigrant nurses during their adaptation period exist in healthcare organisations (Alexis and Vydelingum, 2004, Matiti and Taylor, 2005, Xu, 2007). This study also revealed the mismatch between immigrant nurses’ skills and the positions they fill and that without additional support this adds strain to their successful adaptation. In our study immigrant nurses who were new to the ICU environment with little specialist knowledge in ICU were expected to hit the ground running with little support mechanisms. These kind of rules and resources used to recruit and utilise immigrant nurses not only threatens the quality of care delivered to patients (Plotnikova, 2012), but also the rapport between immigrant nurses and host nurses. The support mechanisms for immigrant nurses to adapt practice reported in the literature vary ranging from no support to assigning a junior nurse to be a mentor for an experienced immigrant nurse, using culturally inappropriate instructions or racist attitudes to correct the immigrant nurses’ practice (Alexis and Vydelingum, 2004, Allan et al., 2004, Jose, 2011). The consequences of these inadequate supports are low self-esteem, feelings of losing face, cultural pain and alienation between host nurses and immigrant nurses. All these compromise workforce integration.

The lack of suitable clinical placements to prepare immigrant nurses to be employed in the areas of their expertise in adaptation programs was identified in our study. A partnership between a university and a healthcare organisation to support employer-sponsored visa program may be one structural solution allowing for sharing of resources in both academic and clinical arenas and meet the learning needs of immigrant nurses while meeting the employer’s expectations in recruiting these nurses. Innovative adaptation programs are reported in the literature with two features: targeting immigrant nurses’ learning needs in
academic settings and providing mentoring or preceptorship in clinical settings (Boylston and Burnett, 2010, Hayne et al., 2009, Thekdi et al., 2011). A program for Korean nurses to gain registration in USA reported by Boylston & Burnett (2010) was offered through a partnership between a hospital and an education institution. The program was designed drawing on research evidence on immigrant nurses’ adaptation to USA culture. Areas covered not only professional topics, but English communication in intercultural encounters. In an adaptation program reported by Thekdi and colleagues (2011), immigrant nurses received 6-months support from preceptors at ward level.

Our study identified that a multicultural team puts additional stress on both host nurses and immigrant nurses as they need to learn from each other and make allowances for team members. Acknowledging the efforts team members make in adapting to the multicultural work environment through organisational arrangements, job descriptions and resource development may mitigate workplace stress that contribute negatively to workforce integration (Dreachslin et al., 2004, Pasca and Wagner, 2011, Pololi et al., 2010). In addition, some senior nurses in our study demonstrated leadership in smoothing over immigrant nurses’ adaptation to the ward by initiating a program for newly employed immigrant nurses, and by organizing a forum for them to interact with host nurses. The findings in our study confirm Giddens’ Structuration Theory that leadership is recognised as an authoritative resource (Giddens, 1984), a powerful mitigating factor to cultural discordance in an organisation (Beheri, 2009, Dreachslin et al., 2004, Hunt, 2007). Groves and Feyerherm (2011) identified that leaders with higher cultural intelligence were more likely to better diagnose behavioural problems arising from the diversity of work teams and respond to these in a culturally
appropriate way. They suggested that cultural intelligence is an attribute of leadership competency.

Studies on intercultural encounters identify that people with a bicultural and bilingual background develop a capacity to switch their cultural code and language when interacting with people from the mainstream culture in order to fit into the group (Pasca and Wagner, 2011, Ting-Toomey, 2010). When they revert to their native language this may be an indication of social attachment of the in-group members, the exercise of ethnocentrism, emotional vulnerability and maladaptation or psychological stress of immigrant nurses (Ang et al., 2007, Pasca and Wagner, 2011, Ting-Toomey, 2010). Further research should be undertaken to explore psychological stress that immigrant nurses experience and how the stress impacts on their adaptation.

Limitations

A number of limitations were identified in this study. First, the use of the Structuration Theory to investigate and interpret structural domination in workforce integration restricted the authors in analysing issues beyond the Theory. Examples can be seen from the theory-based coding under the concepts of actions and conditions (see Appendix 2) and the development of categories and themes that reflect concepts such as rules, resources and consequences from the chosen theory. Therefore, findings from this study only represent a critical perspective of how factors stemmed from social structures can affect nurses’ performance in workforce integration. The authors acknowledge there may be other interpretations of the problem under study, suggesting further investigation and discussion of findings. Furthermore, socially-
culturally-politically generated factors affecting the workforce integration may vary in different countries. As a consequence, the findings from this contextually-based research cannot be generalised, but may be transferred to a similar context.

5. Conclusion

Using a double hermeneutic underpinned by Giddens’ Structuration Theory, our study has extended research on nurse migration into a critical paradigm. Structuration Theory is viewed as a normative theory applied to expose structural domination and to facilitate structural changes in an area of social practice. The ultimate goal of structural change is to bring social integration that promotes reciprocity for all groups of nurse regardless of their country of origin, and system integration that sustains nursing workforce for the better healthcare outcomes for the public.

Based on findings, we strongly recommend that nurse leaders need to take proactive actions to promote equity and fair treatment for all groups of nurses through regular review of policies and critical reflection on issues of discrimination. They also need to demonstrate leadership in developing resources and initiating activities that will facilitate positive intergroup interactions and prepare nurses with leadership in multicultural care teams. We also recommend that both host and immigrant nurses should proactively engage in programs and activities that promote intergroup contact and intercultural understanding. They should also be mindful and sensitive to each other’s culture in intercultural encounters by learning each other’s values, beliefs and communication styles.
References


Clinical Nursing 16 (12), 2252-2259.


Immigrant and Minority Health 13 (4), 697-705.


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<table>
<thead>
<tr>
<th>Country</th>
<th>Identity assessment</th>
<th>Fit to practice</th>
<th>Pass English language proficiency tests **</th>
<th>Pass a competence-based assessment program</th>
<th>Currently practice as a nurse in their home country</th>
</tr>
</thead>
<tbody>
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<td>Australia</td>
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<td>✓</td>
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<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<td>✓</td>
<td>✓</td>
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<td>✓</td>
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<td>✓</td>
<td>✓ and at least 2 years</td>
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<td>✓</td>
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<td>✓</td>
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<tr>
<td>The United States of America</td>
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<td>✓</td>
<td>TOEFL 540 (Paper) or 207(Internet); or TOEIC 725; or IELTS 6.5</td>
<td>Pass NCLEX only</td>
<td>✓</td>
</tr>
</tbody>
</table>

Note: CELBAN=Canadian English Language Benchmark Assessment for Nurses; CRNE=the Canadian Registered Nurse Examination; IELTS=International English Language Testing System; NCLEX=The National Council Licensure Examination-Registered Nurse; OET=Occupational English Test; TOEIC=Test of English for International Communication

*Examples from the College of Registered Nurses of British Columbia, Canada

**Exemption for English test: 1) Australia: Completion of 5 years of education taught and assessed in English in 7 countries: Australia, Canada, New Zealand, Republic of Ireland, South Africa, UK and USA; 2) USA: completion of nursing education in Australia, Barbados, Canada (some universities In Quebec), Ireland, Jamaica, New Zealand, South Africa, Trinidad and Tobago, the United Kingdom or the United States; 3) New Zealand: Exempted for those from Australia only
Figure 1 Giddens’ Structuration theory used to guide this study

Structural changes

Structures: rules and resources

Enable
Inhibit

Actor’s action

Unintended consequences

Reflection via double hermeneutic circles

Intended consequences

Structural changes =

S

tuctural changes

Reflection via double hermeneutic circles

Structures: rules and resources

Enable
Inhibit

Actor’s action

Unintended consequences

Intended consequences
### Table 2 Demographic information of participants (N=44)

<table>
<thead>
<tr>
<th>Categories</th>
<th>Immigrant RNs</th>
<th>Senior RNs</th>
<th>The total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=24</td>
<td>N=20</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
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<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Female</td>
<td>21</td>
<td>13</td>
<td>34</td>
</tr>
<tr>
<td>Age range (mean)</td>
<td>26-46 (34)</td>
<td>33-56 (47)</td>
<td></td>
</tr>
<tr>
<td>Experience prior to Australia (mean)</td>
<td>4-28 (12)</td>
<td>14-37 (23)</td>
<td></td>
</tr>
<tr>
<td>Experience in Australia (mean)</td>
<td>1-4 (2)</td>
<td>4-37 (21)</td>
<td></td>
</tr>
<tr>
<td>Position:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN level 1</td>
<td>22</td>
<td>2</td>
<td>24</td>
</tr>
<tr>
<td>RN level 2</td>
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<td>6</td>
<td>8</td>
</tr>
<tr>
<td>RN level 3</td>
<td>0</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Countries of origin (No. of participants)</td>
<td>China (10)</td>
<td>Columbia (1)</td>
<td>India</td>
</tr>
</tbody>
</table>

### Table 3 Information on focus group and interview (N=44)

<table>
<thead>
<tr>
<th>Focus group and interview</th>
<th>Numbers of participants</th>
<th>Code numbers used for quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immigrant nurses’ focus group one</td>
<td>9</td>
<td>INFG 1 (No. 1 to 9)</td>
</tr>
<tr>
<td>Immigrant nurses’ focus group two</td>
<td>5</td>
<td>INFG 1 (No. 1 to 5)</td>
</tr>
<tr>
<td>Immigrant nurses’ focus group three</td>
<td>5</td>
<td>INFG 1 (No. 1 to 5)</td>
</tr>
<tr>
<td>Senior nurses’ focus group</td>
<td>10</td>
<td>SNFG (No. 1 to 10)</td>
</tr>
<tr>
<td>Immigrant nurses’ interview</td>
<td>5</td>
<td>IM Interview (No. 1 to 5)</td>
</tr>
<tr>
<td>Senior nurses’ interviews</td>
<td>10</td>
<td>SN Interview (No. 1 to 10)</td>
</tr>
<tr>
<td>Categories in interpretative hermeneutic</td>
<td>Themes in critical hermeneutic</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>C1: Unintended consequences when using Employer-sponsored visa</strong></td>
<td>T1: Employer-sponsored visa as a constraint on adaptation (unintended consequences)</td>
<td></td>
</tr>
<tr>
<td>C1.1. Working under the condition of employer sponsored visa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C1.2. Tolerating discriminations by immigrant nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C1.3. Few resources to support transition in a new specialty area</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C2: Unacknowledged rules and resources in care teams as barriers</strong></td>
<td>T2: Two-way learning and adaptation in multicultural teams (unacknowledged rules in intercultural encounters and resources needed for positive interactions)</td>
<td></td>
</tr>
<tr>
<td>C2.1. Variations in nursing practice among countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C2.2. Changing behaviours to adapt immigrant nurses by host nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C2.3. Need resources to debrief and resolve issues in multicultural teams</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C3: Organisation’s rules as barriers</strong></td>
<td>T3: Unacknowledged experiences and expertise as barriers to integration (organisation’s rules)</td>
<td></td>
</tr>
<tr>
<td>C3.1. Unacknowledged specialities and experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C3.2. Be used as interpreters and cultural brokers by colleagues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C3.3. Be used as a specialist nurses in their organisations</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C4: Unquestioned group norms as barriers</strong></td>
<td>T4: Unquestioned sub-group norms as barriers for group cohesion (group rules)</td>
<td></td>
</tr>
<tr>
<td>C4.1. Lacking cultural sensitivities in nurse-nurse intercultural encounters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C4.2. Cultural imposition towards immigrant nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C4.3. Forming groups based on country of origin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: C= Category T=Theme
### Appendix 1 Semi-structured questions used in focus groups and interviews

<table>
<thead>
<tr>
<th>Questions for immigrant nurses</th>
<th>Questions for senior nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have regular contact with the local people or your Australian colleagues outside of workplace (actions)? Could you please describe activities and benefits you have had with Australians (consequences)?</td>
<td>1. Could you please describe what challenges and difficulties immigrant nurses from non-English speaking background may encounter in the workplace (rules and actions)?</td>
</tr>
<tr>
<td>2. Do you have regular interactions with your colleagues from other cultural groups in the staff room during break (actions)? What topics do you usually talk and benefits from these interactions (rules and consequences)?</td>
<td>2. Do you have adaptation programs for immigrant nurses? If yes, could you please describe the components of the program (resources)?</td>
</tr>
<tr>
<td>3. Have you identify any tension between immigrant nurses and Australian nurses or between different cultural groups of nurses in workplace? If yes, could you please describe the nature of tension and list reasons that might have contributed to the tension (rules and consequences)?</td>
<td>3. Could you please describe support and resources that are not available for the adaptation, but should be considered in the future (resources)?</td>
</tr>
<tr>
<td>4. Are there significant differences of nursing practice between your home country and Australia (rules)? Could you please name these differences and describe how you cope with these differences (rules and actions)?</td>
<td>4. Could you please describe what challenges Australian nurses may encounter when working with immigrant nurses from non-English speaking background (rules and actions)?</td>
</tr>
<tr>
<td>5. What support and resources available for you to adapt nursing practice in Australia (resources)? Could you please describe support and resources that are not available, but should be considered in the future (resources)?</td>
<td>5. What resources are available for Australian nurses in order to prepare them to work with immigrant nurses from non-English speaking background (resources)?</td>
</tr>
<tr>
<td>6. Could you please describe major challenges and difficulties you encountered and what strategies did you use in coping with these challenges in the workplace (rules, resources and actions)?</td>
<td>6. Have you identified any tension between immigrant nurses and Australian nurses or between different cultural groups of nurses in workplace? If yes, could you please describe the nature of tension and list reasons that might have contributed to the tension (rules and consequences)?</td>
</tr>
<tr>
<td>7. What means or strategies do you believe work for you to enhance communication with your colleagues and patients in the workplace (rules, resources and actions)?</td>
<td>7. What strategies do you put in place to promote positive group interactions between the immigrant nurses and Australian nurses (resources and actions)?</td>
</tr>
<tr>
<td>8. What was your expectation for orientation and induction programs (resources)? Did the orientation and induction programs meet your expectation (resources)?</td>
<td>8. What strengths do you believe immigrant nurses can bring to patient care in your hospital (resources)?</td>
</tr>
<tr>
<td>9. Could you please describe career opportunities you have been offered since you worked in hospitals in Australia (rules, resources and actions)?</td>
<td>9. What strategies do you believe will improve career development for immigrant nurses (rules, resources and actions)?</td>
</tr>
</tbody>
</table>

**Four concerning areas:**

1. Group interactions: Questions 1,2, 3
2. Challenges nurses faced and strategies used to cope with these challenges: Questions 4, 6, 7
3. Supports for nurses: Questions 5, 8
4. The utilisation of immigrant nurses: Questions 9

---

**Four concerning areas:**

1. Group interactions: Questions 6, 7
2. Challenges nurses faced and strategies used to cope with these challenges: Questions 1, 4
3. Supports for nurses: Questions 2, 3, 5
4. The utilisation of immigrant nurses: Questions 8, 9
### Appendix 2 Examples of codes and categories (selected only)

<table>
<thead>
<tr>
<th>Transcripts</th>
<th>Coding</th>
<th>Grouping and summarising codes</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Concerning area: Group interactions from INFG1 No 4:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>I was employed as an RN 1 year 9. In the very beginning, one nurse said to me in the front of others that I should be in charge of the whole ward in order to be fair enough for other nurses as I got year 9 pay. I told her that I would, but I needed time to be familiar with the work environment.</em></td>
<td>INFG1No4Co1: Be forced to prove ability by host nurses</td>
<td>NFG1No4Co4: Hostile environment during adaptation</td>
<td>Need resources to debrief and resolve issues in multicultural teams (Supported by group codes of “unsuitable environments for adaptation”, “lacking cultural sensitivities”, “benefits of positive intergroup interactions” and “conditions for positive intergroup interactions”)</td>
</tr>
<tr>
<td><em>Then she said if you did not feel confident to take year 9 you should start from year 1.</em></td>
<td>INFG1No4Co2: Threats from host nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>...I had been watched all time and criticised that I shouldn’t do things in the way I was doing.</em></td>
<td>INFG1No4Co3: Picking fault from host nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Concerning area: Group interactions from SNFG No 9</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>I've had them [immigrant nurses] say to me that they would rather start off being paid as an RN year 1 and I say to them you deserve to be paid above that. Sometimes they feel that a pressure because you know on the roster you know the RN year 9’s rise to the top. ....Some staff makes it very difficult for that to happen.</em></td>
<td>SNFGNo9Co1: Surrendering to threats from host nurses</td>
<td>SNFGNo9Co2: Unsupportive environment during adaptation</td>
<td>Lacking cultural sensitivities in nurse-nurse intercultural encounters (Supported by group codes of “Lacking cultural sensitivities”)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Actions</strong></td>
<td><strong>Conditions</strong></td>
<td><strong>Unsuitable environments for adaptation</strong></td>
<td><strong>Cultural imposition towards immigrant nurses</strong> (Supported by group codes)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NFG1No4Co4: Hostile environment during adaptation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SNFGNo9Co2: Unsupportive environment during adaptation</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lacking cultural sensitivities</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>INFG3No2Co1: Exclusion of other groups from conversations in staffroom</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INFG3No2Co2: A low awareness of other culture as a condition for lacking of cultural sensitivities</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Concerning area: Group interactions from INFG 3

It’s very common that for nurses who are from the same country to speak their own language at break time because we are on different shifts we don’t normally see each other so it’s also a good opportunity for us to catch up (INFG 3 No.1).

...one staff complained to me that she felt boring when three of us talked in our language in the staffroom. I recognise that we should be inclusive and engage her in our conversation so we just speak English (INFG 3 No.2).

<table>
<thead>
<tr>
<th>Concerning area: Group interactions from INFG3</th>
<th>INFG 3No1Co1: Attaching to our cultural group</th>
<th>INFG 3No2Co1: Exclusion of other groups from conversations in staffroom</th>
<th>INFG 3No2Co2: A low awareness of other culture as a condition for lacking of cultural sensitivities</th>
<th>INFG1No4Co3: Picking fault from host nurses</th>
<th>SNFGNo9Co1: Surrendering to threats from host nurses</th>
</tr>
</thead>
</table>

Forming groups based on country of origin

(Supported by group codes of “forming groups”)

<table>
<thead>
<tr>
<th>Forming groups</th>
<th>INFG3No1Co1: Attaching to own cultural group</th>
<th>INFG 3No1Co2: In-group communication in native language in staffroom</th>
</tr>
</thead>
</table>

Positive intergroup interactions

<table>
<thead>
<tr>
<th>Positive intergroup interactions</th>
<th>NFG1No1Co1: Positive intergroup communication in staffroom</th>
<th>NFG1No1Co2: Learning from host nurses via intergroup communication</th>
</tr>
</thead>
</table>

Conditions for positive intergroup interactions

<table>
<thead>
<tr>
<th>Conditions for positive intergroup interactions</th>
<th>NFG1No2Co1: Debriefing via intergroup communication in staffroom</th>
<th>NFG1No2Co2: Positive intergroup interaction as a condition to reduce stress</th>
</tr>
</thead>
</table>

SNFGNo10Co1: Leadership in initiating the forum for host nurses to understand immigrant nurses

SNFGNo10Co2: Understanding immigrant nurses’ experiences and...
...it helps us to establish a good relationship. At the end it can improve a patient's safety. If we have a good relationship then we can work together in a much better way and communicate better (NFG1 No.3).

**Concerning area: Group interactions from SNFG No 10**

We held a forum where we got a number of immigrant nurses to tell their stories, cultures and practice from their home countries. The main idea of that forum that we had was we just wanted nurses here to get to know immigrant nurses so that they will be able to support them better and be a bit more patient with them. They were listening very intensely to these nurses they didn’t know them but when the session was over the host nurses were going up to them shaking their hands and introducing themselves to them (SNFG No 10).

<table>
<thead>
<tr>
<th>SNFGNo10Co1: Leadership in initiating the forum for host nurses to understand immigrant nurses</th>
<th>INFG1No3Co1: Positive intergroup interaction as a condition to improve relationships</th>
<th>INFG1No3Co2: Positive intergroup interaction as a condition to improve teamwork</th>
<th>Stories as a condition for positive intergroup interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNFGNo10Co2: Understanding immigrant nurses’ experiences and stories as a condition for positive intergroup interaction</td>
<td>INFG1No2Co2: Positive intergroup interaction as a condition to reduce stress</td>
<td>INFG1No3Co1: Positive intergroup interaction as a condition to improve relationships</td>
<td><strong>Benefits of positive intergroup interactions</strong></td>
</tr>
<tr>
<td>SNFGNo3Co2: Positive intergroup interaction as a condition to improve teamwork</td>
<td>INFG1No3Co2: Positive intergroup interaction as a condition to improve teamwork</td>
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</tbody>
</table>

Note: Co=code; INFG1= Immigrant Nurses’ Focus Group One; INFG1No4= Immigrant Nurses’ Focus Group One and member no. 4; INFG1No4Co1= Immigrant Nurses’ Focus Group One, member no. 4, Code No. 1; SNFG= Senior Nurse Focus Group; SNFG No 10= Senior Nurse Focus Group member No.10; SNFGNo10Co1= Senior Nurse Focus Group member No.10 and Code No. 1