

Exploring the experiences of internationally and locally qualified nurses working in a culturally diverse environment

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ABSTRACT

Objective

This article explores the support needs, attitudes and experiences of both internationally and locally qualified nurses working within a culturally diverse environment.

Design

Open and closed survey questions.

Setting

Hospital in Sydney, Australia.

Subjects

108 nurses were surveyed, representing 14% of the nursing staff at the hospital.

Main outcome measure(s)

The research project measured the experiences encountered by internationally qualified nurses (IQNs) in relation to language use, discrimination, culture and differing health systems. It provided a forum to discuss how their cultural background, professional background and linguistic skills affect interactions with patients and other staff. It also explored suggestions for improvement in cross-cultural relations between staff, and support for IQNs and their peers in a diverse staff environment.

Results

Although IQNs feel they are adjusting well to their role, locally qualified nurses largely disagree. Staff were aware of discrimination from patients towards staff, and from other staff towards staff. The research revealed that IQNs are unsure when to use their language skills, have different approaches to nursing and expectations of the staff-patient/family relationship.

Conclusion

Adjustment to the Australian healthcare system for IQNs is challenging. There are a number of strategies that can support both IQNs in their integration, as well as all nurses to work more effectively together in a cross-cultural work environment.

INTRODUCTION

Hospitals are culturally diverse environments due to the cultural diversity of the Australian population and the recruitment of internationally qualified health professionals. The proportion of the population born overseas has increased from 2011 to 2016 in Australia from 25% to 26% (ABS 2016a), and in New South Wales (NSW) from 26% to 28% (ABS 2016b). Internationally Qualified Nurses (IQNs) are routinely recruited from overseas to assist with shortages in Australian hospitals (Health Workforce Australia 2012). As a result, the percentage of overseas born nurses has increased in Australia from 25% in 2001 to 33% in 2011 (ABS 2013). In 2016, the percentage rose to 38% (Australian Government 2016). 'Overseas born' is defined as those who have gained qualifications overseas and then migrated as well as those who have migrated then gained qualifications in Australia. The countries of origin of the nurses have also changed, with an increase in those from non-English speaking countries (NESC) (ibid; Ohr et al 2010).

Australian and NSW multicultural policies acknowledge the importance of language and intercultural skills of culturally diverse staff in working with clients from culturally and linguistically diverse (CALD) backgrounds (NSW Health 2017; Multicultural NSW 2016; NHMRC 2005). Nursing literature also highlights the importance of these skills (Jeon and Chenoweth 2007; Gerrish and Griffith 2004; Omeri and Atkins 2002; Dreachslin et al 2000). Studies demonstrate that expanding the cultural diversity of health professionals increases effective communication, satisfaction and access to culturally competent health care for patients from CALD backgrounds (Institute of Medicine 2004; Stevens et al 2003; Hawthorne et al 2000; Snowden et al 1995).

While IQNs bring valuable skills to their role, they also face challenges due to language issues, differing approaches towards patient care, unfamiliarity with the health system and culture shock (Ohr et al 2017; Brunero 2009; NSW Government 2008; Konno 2006; Smith et al 2006; Eisenbruch 2001; Wallace et al 1996). Research has also highlighted areas of perceived discrimination for IQNs and nurses from CALD backgrounds (Trenerry et al 2010; Omeri 2006; Blackford and Street 2002). In response to this, resources and programs have been developed to assist overseas trained staff in their transition (NSW Department of Health 2010; Brunero 2009; NSW Government 2008) and some have been evaluated (Tie et al 2018; Ohr et al 2017).

Diversity management involves instilling an organisational culture where diversity is positively acknowledged and valued (Prasad and Mills 1997). In order to instil this culture, structural support is needed beyond just fulfilling Equal Employment Opportunity principles (Tie et al 2018; Hudelson 2004; Bloor 1999). Managing diversity is defined as "planning and implementing organisational systems and practices to manage people so that the potential advantages of diversity are maximised while its potential disadvantages are minimised" (Cox 1993, p11). This literature discusses the organisational benefits when staff have the skills to work with staff and clients from CALD backgrounds (Weech-Maldonado et al 2002). Despite the benefits, there has been limited research and program development on diversity management in the United States of America (USA) and Australia (Klinken Whelan et al 2008; Dreachslin et al 2004; Weech-Maldonado et al 2002).

At a hospital in Sydney, the Diversity Health Coordinator (DHC) received feedback from the nursing department and culturally diverse staff that there was a need to assess whether internationally qualified and CALD nurses felt sufficiently supported. The DHC then conducted key informant discussions with nursing managers and IQNs to assess the situation. This raised a number of support issues for internationally qualified and locally qualified nurses, as well as for the organisation. Nursing managers were often unprepared upon IQN arrival, and IQNs themselves lacked information about their placement. While other hospitals in the area had been employing IQNs for some time including those from NESCs, at this hospital more IQNs were coming from NESCs than previously and it was not fully prepared for their needs.

Nursing managers were also concerned about the quality of the bridging courses for IQNs. There were also

reports of different caring practices such as some nurses expecting to provide more clinical rather than personal care, as this was usually managed by family in their home country. Anecdotal reports were also provided about some nurses expressing different cultural views about death and dying such as letting elderly patients die with dignity rather than prolonging their lives artificially. There were also instances where the hierarchical social class structure in the home country, such as the caste system between nurses originally from India, was impacting on the allocation of nursing tasks. There were also concerns about the exclusion of other staff members when bilingual staff used their home language with peers during communal breaks.

These concerns highlighted the need to initiate a research project to explore the experiences of all nurses working within an increasingly diverse environment. While previous international research has examined the experiences of IQNs (Omeri 2006; Blackford and Street 2002), this research examined the views of *both* internationally qualified and locally qualified nurses as these often conflicting workplace practices appeared to be impacting on both groups. It was anticipated that gaining a full understanding of each perspective would inform recommendations that would benefit all nurses. In particular, it aimed to: explore IQNs experiences in terms of language use, culture and differing health system experiences; explore how all staff experience the diverse staff environment; provide a forum for staff to provide feedback on IQN orientation; explore suggestions for improvement in cross-cultural relations; and recommend support for IQNs and their peers.

METHODS

In 2012, a steering committee was established to guide the objectives of the project. The committee consisted of representatives from Diversity Health, Education & Training, Human Resources, Employee Assistance Program, Nursing and Multicultural Health Service. After attempts to conduct focus groups with nurses were unsuccessful, an anonymous semi-structured survey entitled "Working in a Culturally Diverse Staff Environment" was developed based on the aims of the project and distributed to all nursing staff in March 2014. Ethics approval was also gained from the local health service ethics committee. With the support of the nurse unit managers, 602 survey packages were delivered to various hospital wards.

FINDINGS

Of the 602 surveys distributed, 108 surveys were returned indicating a response rate of 18% (14% of the nursing pool of 786). The surveys were then analysed to reveal trends. Although the survey consisted of quantitative and qualitative items, the information was mainly analysed in a qualitative way according to patterns in the research (Liamputtong Rice and Ezzy 1999) due to small numbers in some respondent groups.

Clear trends emerged in the data that allowed for division of the respondents into two distinct groups: English speaking background (ESB) respondents and non-English speaking background (NESB) respondents. The ESB group consisted of i) Australian born nurses and ii) nurses born overseas in English speaking countries (ESC) who were qualified in Australia or in other ESCs. The NESB group consisted of nurses who were i) born in a NESC and Australian qualified, ii) born and qualified in a NESC and iii) an unidentified group that did not indicate where they were born or qualified. The unidentified group showed the same trends as the NESB groups therefore it was integrated into this group. Thus, the ESB group consisted of 79 respondents (73%) and the NESB group of 29 respondents (27%) (see figure 1).

The survey responses were analysed and grouped into categories according to patterns in the research. Themes included acceptance, level of discrimination, use of second language, approaches to caring and social adjustment.

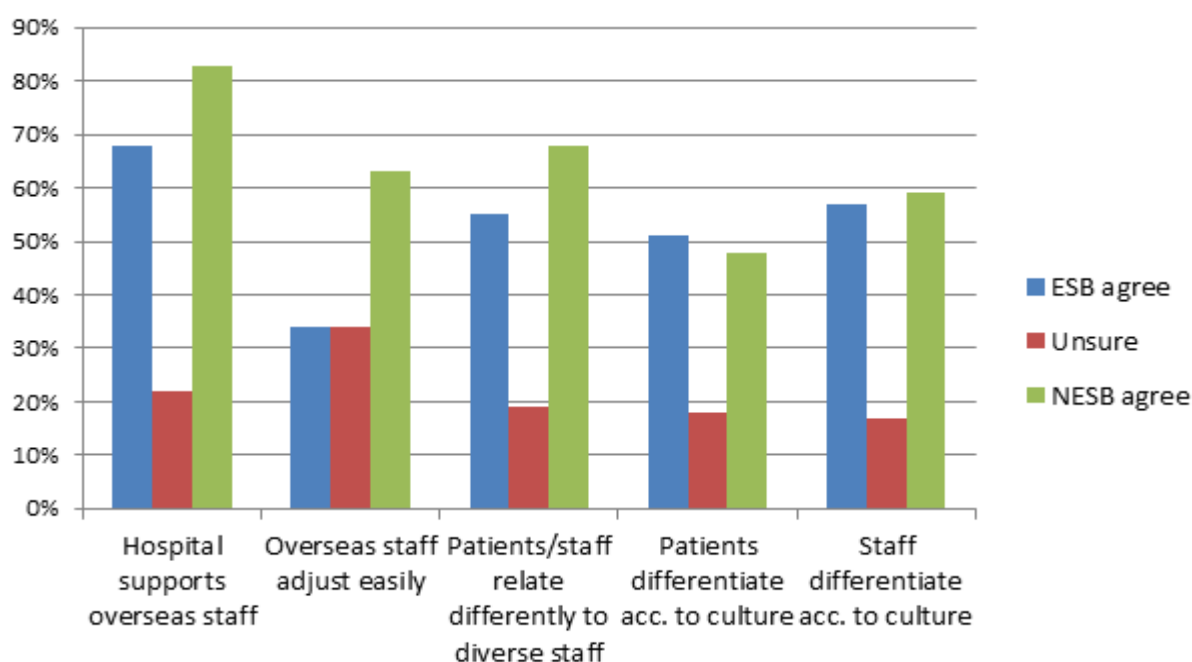
Figure 1: Groups and subgroups of respondents

Groups	Subgroups	Respondents
ESB respondents (73%)	Australian born nurses	63%
	Nurses born overseas in an ESC and qualified in Australia or overseas in ESC	10%
NESB respondents (27%)	Nurses born in NESB and Australian qualified	13%
	Nurses born and qualified in NESB	11%
	Unidentified nurses	3%

Acceptance of culturally diverse staff

Most staff reported the workplace was supportive of IQNs. Of all the staff, it was the NESB staff that felt the hospital was the most supportive. NESB staff also felt they adjusted more easily to the workplace than their ESB colleagues felt they did.

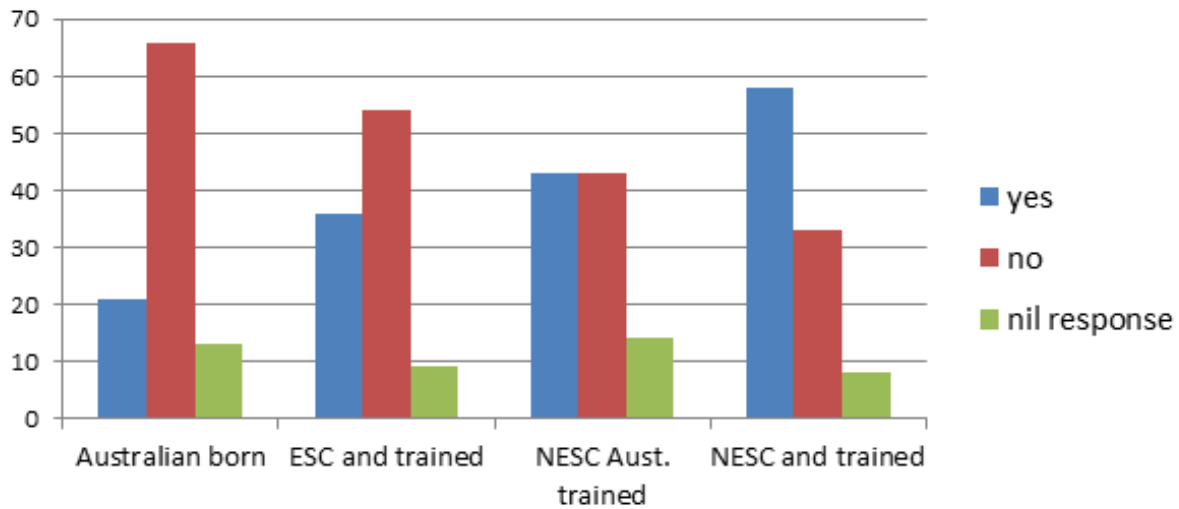
Staff were also asked whether staff and patients relate differently to culturally diverse staff. The majority of respondents agreed that staff and patients do relate differently, with NESB nurses more likely to report this than ESB staff. Slightly more ESB staff reported *patients* related differently to the cultural background of staff, and more NESB reported *staff* related differently to the cultural background of staff. The trend of relating differently was observed more for staff than patients. Figure 2 outlines this data.

Figure 2: Agreement with statements regarding acceptance of culturally diverse staff**Level of discrimination**

Overall, 30% of all respondents felt there was discrimination in relation to the cultural background of staff. Perceptions of discrimination differed with only 23% of ESB staff agreeing there was discrimination compared to 50% of NESB staff. Figure 3 outlines subgroup perceptions about discrimination.

Responses were similar across both NESB and ESB groups with regard to the most common areas of discrimination, which included 'being left out of discussions' followed by 'workload allocation', 'being given responsibility' and 'opportunities for career development'.

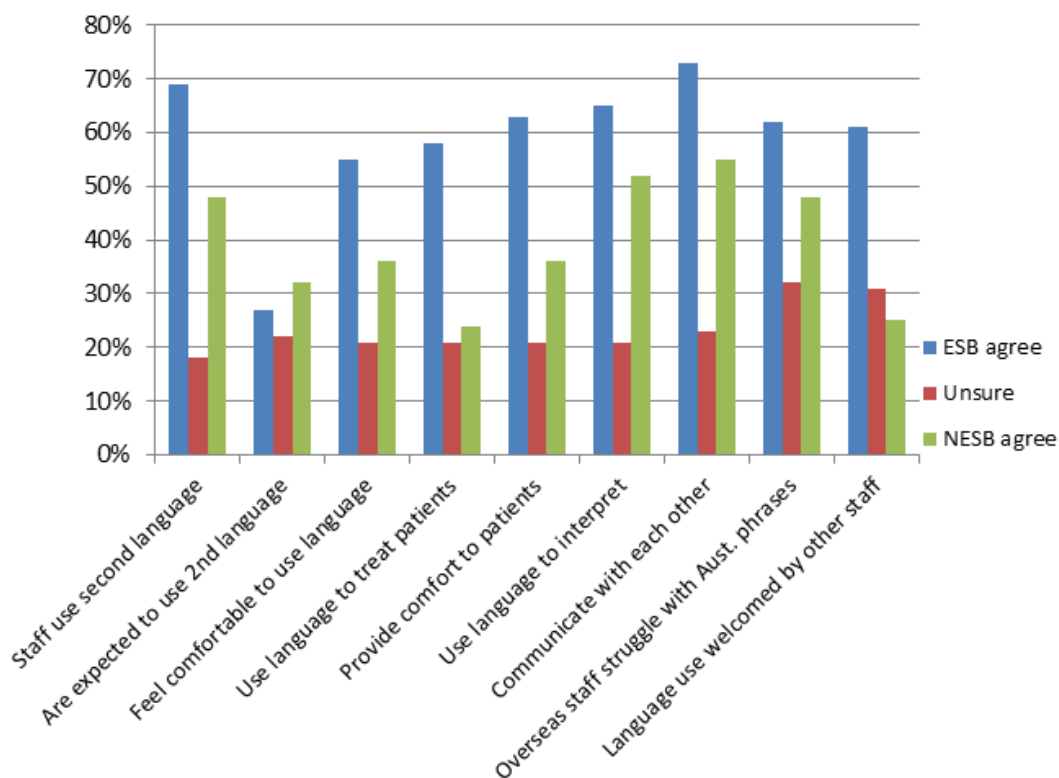
Figure 3: Agreement discrimination exists according to staff cultural background



Use of second language in the workplace

Perceptions of how language is used in the workplace, and when it is appropriate to use it, varied across groups. A number of questions in the survey were used to better understand the use of a second language both amongst staff and with patients. Figure 4 sets out the different perceptions of how languages were used.

Figure 4: Agreement with statements regarding use of second language in workplace



NESB staff were half as likely as ESB staff to report that a second language was welcomed by patients. In fact, a number of NESB born and qualified staff strongly disagreed that patients and families welcomed a second language. NESB staff reported that they struggled much less with Australian phrases and sayings than ESB staff believed they did.

The majority of NESB and ESB groups agreed that bilingual staff were not expected to use their language. ESB staff believed bilingual staff used, and were comfortable to use, their second language at work more than NESB staff. In fact, many NESB staff reported feeling uncomfortable using their second language.

There were also differences in the perceptions of when bilingual staff used their second language. While ESB staff mostly reported it occurred to treat and provide comfort to patients, most NESB staff disagreed. ESB staff mostly agreed that bilingual staff use their language to communicate with each other, while NESB staff were divided. Both ESB and NESB groups mostly agreed that bilingual staff use their second language to interpret for other staff, despite less than 20% of all staff agreeing that this was appropriate.

Comments provided about when staff thought it was appropriate to use another language indicated a degree of confusion. There were also differing opinions about the desirability of using a second language in the workplace. ESB staff felt that the most appropriate use of a second language was in patient focused situations, while NESB staff felt it was on break time and to communicate with other staff. Interestingly ESB staff felt this was the most inappropriate use of a second language. The most common inappropriate use of language reported by NESB staff was in the workplace, including the ward and nurses' station. Both groups recognised that it was inappropriate to use a second language in front of non-bilingual staff.

Approaches to caring

ESB staff were evenly divided in their opinion of whether or not nursing practices differ between Australian and IQNs. NESB staff however, were less likely to identify differences. Australian born staff and those who were ESC born and trained identified a number of areas in which those differences occurred. The areas of most difference identified by Australian born staff were 'personal care of patients', 'relationships between staff and their patients/families', and 'expectations of how patients/families should behave'. NESB born and trained staff identified fewer areas of care where there were differences. In contrast to ESB staff, no NESB born and qualified staff identified differences in personal care and relationships between staff and their patients/families. This indicates a significant disparity between the observations of the two groups. The area identified most by NESB staff was 'expectations of how patients/families and their visitors should behave'. No NESB staff identified that there were differences in approaches to care in the areas of mental health, end of life or medication and pain management. Interestingly NESB Australian trained staff had similar perceptions as Australian born staff in all areas except with regard to end of life care, where they were more likely to identify different approaches to care.

Social adjustment and support

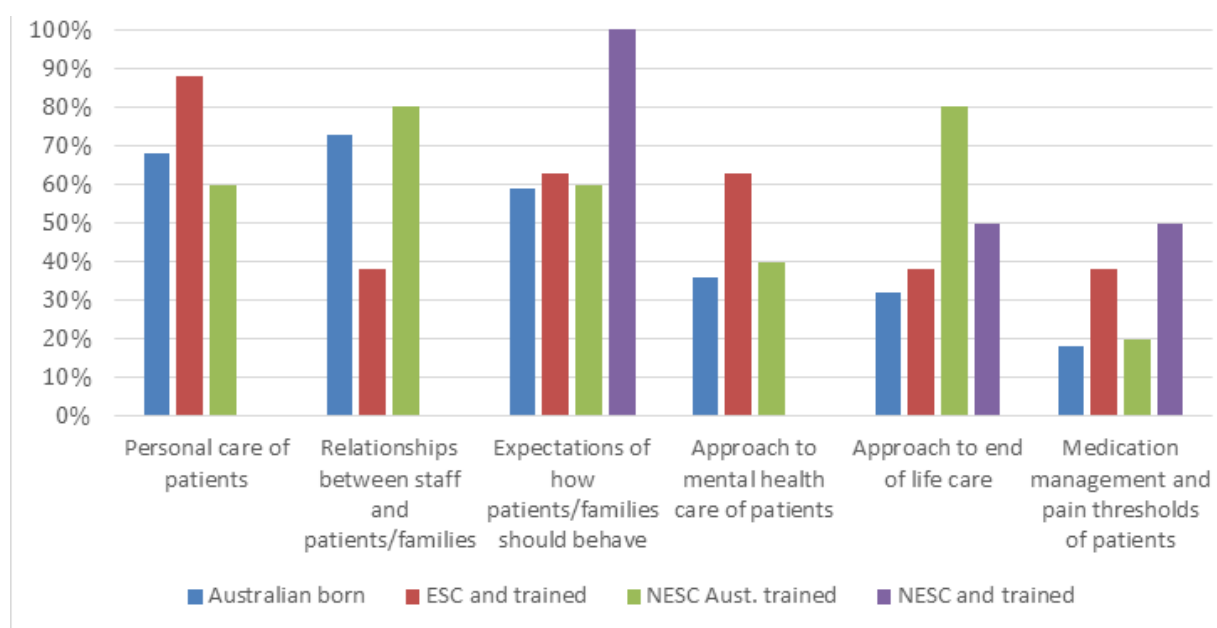
Respondents were asked to comment on the adjustment of IQNs to working in the Australian health care system and what support could be provided. The issues identified by ESB staff included adjustment to nursing roles in Australia, their expectations and understanding of practices, acknowledgement of difficulty, social hierarchy back home impacting on work behaviour and the need for support and supervision. Assistance identified by NESB staff included support from management and nurse educators, more orientation to the Australian nursing system, guidance on acceptable behaviour, and allowing time to adjust.

There were similar suggestions from all respondents to support newly arrived IQNs including how to understand Australian cultural norms, colloquialisms and the healthcare system. ESB staff were more likely to identify

'understanding Australian medical terminology and jargon' as an issue than NESB staff. This may indicate that NESB staff are not aware of the gaps that exist in this area.

The most common recommendations across both groups to what would assist *all* staff working in a culturally diverse environment were 'mentoring/buddy system', 'team building activities', and 'workshops for all staff on working cross-culturally in the workplace'.

Figure 5: Areas in which different approaches to care were identified



DISCUSSION

The findings raised issues in relation to cross-cultural staff relations, communication skills, use of a second language, different ways of caring and social adjustment and induction.

Cross-cultural staff relations

Overall staff were supportive of IQNs, with more NESB than ESB staff feeling the hospital was supportive and that IQNs adjusted easily. The results indicated that the cultural background of staff does impact on staff relations and those with patients. Differences mainly felt by NESB staff indicated that they are quite aware that some staff are treated more positively than others.

Discrimination was perceived by all groups and more so for NESB. Overall, 30% of all respondents felt there was discrimination in relation to the cultural background of staff from both staff and patients. This rate was higher than the NSW Health 2015 survey which indicated 15% of staff have experienced discrimination by a patient, colleague or manager (NSW Government 2015).

Research has also highlighted areas of perceived discrimination for nurses from CALD backgrounds (Trenerry et al 2010; Blackford and Street 2002). Studies in Australia (Omeri 2006; Hawthorne 2001), the United Kingdom (Smith et al 2006; Gerrish and Griffith 2004; Allen and Larsen 2003; Ward 1993), Canada (Turritin et al 2002) and the USA (Dreaschlin 2000) indicate that IQNs have perceived discrimination from other staff as well as patients. This may be under reported as staff may be reluctant to discuss this with their superiors as they are afraid of negative repercussions to their employment (Jenkins and Huntington 2015) and may not fully understand their rights.

The areas of perceived discrimination mainly concerned opportunities for promotion, responsibility and work load. This is consistent with other research conducted with IQNs (Jenkins and Huntington 2015; Tregunno et al 2009; Kingma 2008; Larsen 2007; Alexis et al 2006; Culley and Mayor 2001). Deegan and Simkin (2010) discuss IQNs feeling they lack autonomy and support by other nurses on the basis of their ethnicity or background. However, senior staff were reluctant to advance IQNs due to a lack of familiarity, awareness of certain clinical tasks and concerns about safety. Other research indicates that management may be hesitant to promote IQNs as they are not permanent staff (Gerrish and Griffith 2004). This highlights the need for proper training, support and supervision in clinical nursing areas in which they are unfamiliar.

The psychological impact of discrimination on IQNs as effecting the quality of patient care has also been discussed in the literature (Deegan and Simkin 2010; Kingma 2008; Xu and Kim 2008; Omeri 2006;). This highlights the need for NESB staff and local staff to debrief, receive support and for cross-cultural relations to be enhanced (Deegan and Simkin 2010). All categories of staff in this research indicated that cross-cultural workshops and team building activities would be helpful. This approach has also been supported in the diversity management literature (Alexis et al 2007; Whelan et al 2005; Weech-Maldonado et al 2002; Dreachlin 1999) and nursing research (Tie et al 2018; Ohr et al 2017; Brunero 2009). Other noted activities include conducting staff surveys to measure discrimination (NSW Health 2009; NSW Government 2008; Dreachlin 1999) and compare this by cultural background (Weech-Maldonado et al 2002). Staff should also be informed about anti-bullying policies and procedures (Nursing and Midwifery Board 2015), and those in leadership roles trained in how to identify and manage discrimination appropriately.

Use of second language

Perceptions varied across groups of when and how to use a language other than English (LOTE), reflecting a lack of clarity in the NSW Health policy (NSW Health 2017). Policies indicate staff can use a LOTE in direct patient care but they do not specify what level of proficiency is needed or in what situations.

Our research indicated that NESB staff did not feel comfortable using their first language in the workplace. They reported they used it much less frequently than ESB staff thought they did. NESB staff were also half as likely as ESB staff to report that their native language was welcomed by patients. The fact that few bilingual respondents spoke a LOTE that is commonly present in the patient population may have been a factor in these responses.

ESB staff felt it was inappropriate for NESB staff to communicate in their shared language with other NESB staff. NESB staff however thought this was appropriate, indicating a need to explore and clarify this issue further with staff. Policy for IQNs states "If you speak a language other than English you may find you can use this skill in the course of your work" but does not clarify in which contexts (NSW Health 2010, p19). Approaches to this issue have generally included the need to respect the Code of Conduct and respect fellow workers (Nursing and Midwifery Board of Australia 2018).

The findings also indicate NESB staff often interpreted for other staff, despite this being contrary to policy (NSW Health 2017). This demonstrates the need for more clarity and discussion of bilingual staff use of a LOTE in the workplace, and when a professional interpreter should be used.

Communication Skills

NESB staff were less likely to report difficulty with Australian phrases and sayings than ESB staff. Most NESB born and trained staff who disagreed that they struggle with English language have lived in Australia for less than 10 years which may contribute to their inability to recognise difficulties. Likewise, NESB staff were less likely to identify 'understanding Australian medical terminology and jargon' as areas of support. These findings indicate that language support, particularly during the early period of settlement and adjustment,

is crucial. Various research and reports have highlighted the need to assist IQNs with communication skills in the area of colloquialisms, abbreviations, terminology and idiom to improve patient safety (Tie et al 2018; O'Callaghan 2015; Deegan and Simkin 2010; NSW Department of Health 2010; Takeno 2010; Brunero et al 2008; Francis et al 2008; Jeon and Chenoweth 2007; Konno 2006; Weech-Maldonado et al 2002). "Nursing English" classes have also been recommended for IQNs across NSW which focus on pronunciation, intonation and functional language as well as face-to-face workshops to discuss cultural and language differences (Brunero 2009). While IQNs must pass strict English language requirements (Nursing and Midwifery Board of Australia 2015; Hawthorne 2012), they may still need assistance practicing these language skills in the fast-paced hospital environment.

Different approaches to caring

ESB staff reported differences in approaches to caring more than NESB staff, including 'personal care of patients' and 'relationships between staff and their patients/families'. In contrast no NESB born and trained staff identified differences in either of these two areas. This demonstrates that IQNs lack information about the different ways that nursing is provided in Australia and are not aware of the differences.

Other research has discussed different approaches to care for IQNs. For instance, Gerrish and Griffith (2004) discusses the difficulty that IQNs face due to different practices, and the time it takes to ensure practices are safe. In some countries nurses have more responsibility in giving injections and may not provide personal care (Francis et al 2008; Konno 2006).

The need for better orientation and induction into different care arrangements has been noted in research and reports (Tie et al 2018; O'Callaghan 2015; Brunero 2009) and is an area that needs to be addressed nationally and institutionally (Brunero 2009; Eisenbruch 2001). Better understandings of care arrangements and standards would promote patient safety and may address areas of discrimination.

Social adjustment and induction

The findings indicated ESB staff perceive there are more difficulties and need of support for IQNs than NESB staff. Issues related to the impact of social standing overseas have been discussed in research conducted in rural Australia (Francis et al 2008) and were reported in our study. Staff coming from more hierarchical structures overseas may also be more fearful of authority in Australia (Tie et al 2018; Gerrish and Griffith 2004). This highlights the need to explain more collaborative forms of communication in Australian health care systems between managers, staff and patients (Tie et al 2018; O'Callaghan 2015).

While some literature has recommended a mentoring system to assist IQNs (Weech-Maldonado et al 2002), research has demonstrated that social support needs to occur in a sensitive way so that mentors are appropriately trained to support specific needs (Allan 2010; Brunero 2009; Konno 2006). The mentor would assist the IQNs to adjust as well as to assist other locally qualified staff understand their needs (Western Australia Government 2006; NSW Nurses and Midwives Association 2012).

The managing diversity nursing literature promotes an organisational culture where staff see diversity as a positive (Dreachslin et al 2004; Cope and Kalantzis 1997), and systems and services are in place to enable better induction for IQNs (Tie et al 2018; Brunero 2008). Our research revealed NESB staff could be better supported and welcomed by staff. Other research has discussed how staff from diverse backgrounds bring a range of different experiences and skills, however locally trained staff did not find this knowledge useful (O'Callaghan 2015; Blackford and Street 2002). Resolving this situation would involve promoting diversity in the organisation (Weech-Maldonado et al 2002), ensuring adjustment and induction procedures for IQNs are in place and thereby create a supportive environment for all staff.

LIMITATIONS

Findings and recommendations presented here are based on survey results of voluntary participants from one hospital. This study used a relatively small sample size from the overall number of nursing staff. For these reasons, it is difficult to generalise findings as applicable to all nursing staff in hospitals. The survey design also meant that views could not be checked or explored in more detail. The original intention was to conduct focus groups with nurses so as to holistically understand the experience and the range of factors affecting their experience. While there was initial interest from IQNs to participate, this was not the case later on so an anonymous survey was designed. Recommendations may assist other health settings as well as further research on successful models of induction.

RECOMMENDATIONS

Based on the findings, the following recommendations are presented:

- Develop a webpage for IQNs to access prior to arrival which provides information about the hospitals, their location and Australian approaches to nursing care.
- Strengthen the peer mentor program to provide extra support to IQNs.
- Extend the orientation phase over a three-month period for IQNs.
- Implement an acculturation course for IQNs within three months of their commencement that explains Australian norms, nursing in Australia and communication issues.
- Deliver seminars for all nurses to promote awareness of differing models of nursing overseas.
- All staff to undertake cross cultural training and include guidelines on bilingual staff use of their LOTE.
- Promote awareness of anti-discrimination policies, programs and support.

CONCLUSION

The research revealed that NESB and ESB staff have different opinions of the experiences and support of IQNs. IQNs do not feel comfortable, are unsure when to use their language skills, have different approaches to nursing care and expectations of the staff-patient/family relationship. Although IQNs feel they are adjusting well into their role, ESB nurses largely disagree which likely indicates that IQNs cannot assess that with which they are not familiar. They are too new to have been exposed sufficiently to the Australian English language and the nuances of their role. There were some similarities in that most staff across all groups are aware of a level of discrimination from patients to staff, and staff to staff. Overall, a number of strategies can support IQNs in adjusting to nursing in Australia and all staff working together. Nursing leadership can also assist in developing an open non-discriminatory environment that supports rapid integration of IQNs. These recommendations support the need for policy and guideline development in managing diversity at organisational and national levels.

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