

**Exploring the Integration Experiences of Internationally Educated Nurses (IENs)
within the Canadian Health Care System**

Ndolo Njie-Mokonya, RN, BScN

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School of Nursing
Faculty of Health Sciences
University of Ottawa

Abstract

The number of internationally educated nurses (IENs) in Ontario is growing. Given the predicted nursing shortage due to an aging nursing workforce and a short supply of nursing graduates, this trend will probably continue as international recruitment to meet nursing demands in Canada continues. Current Canadian research that examines IENs' experience as they integrate into their workplaces is scarce. With an increasingly diverse Canadian and patient population due to rising immigration trends, a workforce that addresses the needs of the diverse patient population is valuable. Therefore an in-depth understanding of IENs' experience, their contribution to nursing practice, and their distinct role in promoting health care access to Canada's diverse population is necessary. A qualitative study using descriptive phenomenology was used to explore the integration experiences of eleven IENs within the Ontario, Canada health care system. Interviews were conducted to examine their experience of integrating into Canadian work settings. Thematic analysis informed by a descriptive phenomenological lens was used to uncover the essence of the IEN's integration experience. The findings are categorized into five major themes including: Relationship with colleagues; Professional knowledge and experience; Organizational practices and work environment; Cross-cultural and linguistic competence; and IENs as an asset to nursing and patient care. These findings were nested within an overarching theme of resilience and an intrinsic motivation to establish their credibility as competent nurses. These findings highlight IENs' unique integration experiences, and contribute to Canadian literature in the field, especially in terms of an understanding of IENs' unique contribution to nursing in Canada. Implications and recommendations for nursing with regards to practice, education, research, and administration are presented.

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Chapter One – Introduction

Canada is among the developed nations that recruit internationally educated nurses (IENs) as a result of shortages in the workforce. Over the past decade these shortages have resulted from such factors as an aging nurse population, early retirement, and a short supply of graduating nurses (Canadian Institute for Health Information [CIHI], 2010; Health Canada, 2004; O'Brien-Pallas et al., 2003). A CIHI (2011) report shows that in the province of Ontario 11,230 (8.6%) of Registered Nurses (RNs) graduated outside of Canada. According to CIHI (2010), the primary source countries of IENs in Canada are the Philippines (31.6%) and the UK (17.6%). Other countries accounted for 27% of IENs. In Ontario, IENs make up 11.9% of RNs, which, is above the national average of 8.3% (CIHI, 2010). In this chapter, I will present an overview of IEN experiences within the Canadian health care system. Next, I will present the research purpose of the study and discuss its significance. Due to limited Canadian research in this area, I drew from existing studies in the field from other Western nations that recruit IENs. Then I will introduce myself as the researcher and situate myself within the study. The definition of key terms will conclude this chapter.

An Overview of IEN Experiences Once in Canada

IEN migration to Western countries, including Canada, is a result of economic globalization. Skilled workers made up 64.1% of immigrants in 2009 (Citizenship and Immigration Canada [CIC], 2009) and in response to these migration trends, the government of Canada launched a \$30 million integration plan to accommodate internationally trained health professionals (CIC, 2012). Examples of such projects include the evaluation of foreign academic and workplace credentials, language training, and internship and mentorship

programs. One of the ways which nurse migrants have been reported to gain entry into Canada and other Western nations is through the general class visa category (Bordt, 2002; Buchan, Parkin, & Sochalski, 2003; Torgerson, Wortsman, & McIntosh, 2006), therefore complete and consistent data on the number of IENs (and other health professionals) in Canada is lacking. Consequently, an appraisal of the outcomes of IENs in Canada in terms of financial costs (both to IENs and to the institutions that integrate them) and patient care service delivery is probably underestimated.

The effective utilization and integration of IENs within work settings is important for both patient safety and nursing service delivery. Even though IENs are a valuable addition to the nursing workforce in Canada, they face documented challenges. Little (2007), for example, outlines a three-step process of the challenges that IENs face: as they move through the application process, in their assessment of eligibility to write the licensing exams, and in successfully passing the exams. Other studies have also suggested IENs encounter challenges pertaining to applications and evaluations for eligibility to take the licensing exams (Hawthorne, 2001; Jeans, Hadley, Green, & Da Pratt, 2005; Kingma, 2007; McIntosh, Torgerson, & Klassen, 2007; Ogilvie, Leung, Gushuliak, McGuire, & Burgess-Pinto, 2008). Baumann, Blythe, Rheaume, and McIntosh (2006) claim that it may take several years to complete all three steps successfully.

Once IENs gain employment as nurses, they may find that they experience frustration, struggle, conflicts with, and mistrust by, their nursing colleagues as they transition into their work environment in their host countries. These studies provide insights into those experiences (Jose, 2011; Kawi & Xu, 2009; Magnusdottir, 2005). In Canada, Blythe and Baumann (2009) suggest that differences in educational training could be a

contributing factor to variances in how IENs move through the process of becoming RNs in Canada. Based on the range of studies available, it is clear that the examination of the barriers facing IENs prior to their integration into their work settings within host countries is a concern both in Canada and internationally. In Canada, however, the body of knowledge that examines the integration experience of IENs as RNs once they have been licensed is scarce.

Tregunno, Peters, Campbell, and Gordon (2009) examined how IENs transitioned as nurses into the Canadian health care system and further suggested a framework to facilitate their transition. This qualitative study involved 60 nurses made up of RNs and Registered Practical Nurses (RPNs) who worked in acute care, long-term care, and in community settings in Ontario. Data was collected over a four month period through semi-structured interviews that lasted for approximately one hour. The authors identified three core areas of struggle for IENs during their transition into various workplaces, including “standards of care, language and being the outsider” (p. 188). These areas are consistent with findings from previous studies (Blythe et al., 2006; Magnusdottir, 2005; Turriffin, Hagey, Guruge, Collins, & Mitchell, 2002). New findings identified by Tregunno et al. (2009) pointed to the “role of patients and families in decision-making” and “differences in resource utilization” (p. 188). IENs, for example, perceived it as novel that patients and their families are consulted, and their input considered, before decisions about their care are made. Furthermore, differences in resource utilization were noticed by IENs who discovered that, in Canada, resources such as dressing trays or topical ointments that are kept on the nursing units for patient use were wasted in an attempt to adhere to certain hospital policies, such as infection control.

Additionally, Tregunno et al. (2009) pointed out the possibility of compromised safety in patient care delivery. Experienced IENs who may be experts in various areas of their nursing practice may become novices in a different cultural environment (Tregunno et al., 2009). An IEN from an African or Asian background can be an expert obstetrics nurse, for example, but when in a Canadian work setting may feel like a novice due to their lack of eloquence in the English language. The authors further suggest that by using the novice-to-expert framework (Benner, 1985), specific growth areas, like language fluency or medication prefixes and suffixes, can be supported to enhance IENs' work-place transition.

Other researchers have examined the experiences of IENs prior to obtaining RN licensure (Blythe & Baumann, 2009; Kolawole, 2009). Kolawole (2009) claimed that 40% of IENs in Ontario fail to complete their application process. This is partly due to a lack of clarity in the application process and related policies. For example, IENs may not be fully aware of all aspects of the application process and therefore they may encounter hindrances during credentials and language fluency evaluations. Extra financial costs may be incurred as a result. To address the lack of clarity in the application process, Kolawole proposed that initiating it prior to immigrating to Canada, for example, could reduce waiting time. Frequent updates to CIC's website describing the complete application process involved, including the steps that can be initiated prior to immigrating to Canada, could help to accomplish this.

Current evidence in the field tends to focus primarily on licensure test numbers, pass rates, ethical dilemmas associated with hiring internationally educated nurses from under-developed nations, and various challenges encountered by IENs with qualifications in taking their license exams (Blythe et al., 2006; Kolawole, 2009; Magnúsdóttir, 2005; McIntosh et al., 2007). Three studies done in Canada have described the experience of transition for IENs

after becoming licensed nurses (O'Brien-Pallas & Wang, 2006; Tregunno et al., 2009; Turriffin et al., 2002). More studies that examine how to acquire the necessary information that will enrich Canadian nursing practices, patient care, and the quality of hospital services, and inform and facilitate the integration of IENs, will benefit the Canadian health care system. Using a descriptive phenomenology method, this research hopes to deepen current understanding about the experience of IENs at their various places of work and to generate new knowledge that will inform program development to ensure seamless integration of IENs into the Canadian health care system.

Research Purpose

The purpose of this research is to explore the lived integration experiences of IENs during the first five years of their practice as RNs (i.e., after successfully obtaining licensure to become RNs in Canada) with special attention to the meaning this has for them.

Research Objectives

The objectives of this study are: a) to examine the nursing practice integration experiences of IENs working in one major city in Ontario; b) to explore the meaning of these integration experiences for IENs; and, c) to contribute to a comprehensive understanding of IEN experiences with patient care in Canada.

Significance of the Study

This study contributes to the development of new knowledge given the scarcity of studies in Canadian literature that address IENs' experience as RNs. The study addresses certain gaps in the field including explaining the meaning of the lived experience of IENs at their various places of work. Findings from this study add to the description of this phenomenon in different settings within the field of nursing in the Canadian health care

system as well as increase our current knowledge on this topic. Understanding the experiences of IENs as RNs within Canadian work settings is necessary in order to facilitate the creation of support programs that will enhance their effective integration, promote skill acquisition and utilization, and foster a favourable work environment with their colleagues. When such experiences are inadequately understood, patient care, effective human resource work relationships, and nurse wellbeing is likely to be compromised. This could lead to an impaired IEN-patient therapeutic relationship based on miscommunication, weakened collaboration between IENs and their professional colleagues, and poor utilization of the valuable IEN skill set (Allan & Larsen, 2003; Matiti & Taylor, 2005; Omeri & Atkins, 2002; Tregunno et al., 2009; Turrittin et al., 2002; Yi & Jezewski, 2000).

Challenges with language comprehension and proper communication have been cited as obstacles for IENs as they begin their nursing practice careers (Allan & Larsen, 2003; Magnúsdóttir, 2005). Nursing practice takes place within social contexts and environments, where the nurses' verbal and non-verbal communication or the lack thereof, impacts the patients' perceptions of the nurse's capabilities and ability to deliver care. For example, the nurse's ability to clearly communicate information to patients and their families in a manner that is understood is vital for a healthy nurse-patient work relationship. The perceived inability to clearly communicate is evident in Allan and Larsen's (2003) qualitative study involving sixty-seven nurses. The authors suggested IENs experienced disrespect as a result of their heavy accents which was misinterpreted as an inability to clearly communicate, and consequently, patients mistrusted their care. Aspects of non-verbal communication resulting from cultural differences such as maintaining eye contact with patients were also cited in Allan and Larsen's (2003) study. Another example of communication barriers related to the

unfamiliarity with Western nursing practices was also cited in Bohnen and Balantac's (1994) classic study that involved onsite visits to academic institutions across ten selected countries that offered nursing bridging programs to IENs. Findings suggested that the majority of IENs were exposed to certain medical terminology and practice expectations for the first time in their careers during these training programs. In Canada, Baumann et al. (2006) stipulate that IENs face communication challenges that are not work-related, particularly in understanding certain jokes or words pertaining to the Canadian culture, which can hinder their workplace integration. These communication barriers may obstruct positive patient-nurse relationships, as well as quality and timely care provision in the unit as a whole. This thesis research aims to provide insight into how these experiences influence IENs and how IENs may best be supported during the integration period at their places of work. It also provides insight for other nurses or healthcare professionals who work with IENs, for those who create integration programs at health care institutions, and for IENs who may experience this phenomenon in the future.

Examining how IENs integrate into their practice settings is also essential to enlighten and evaluate the effectiveness of educational bridging programs in Ontario that some IENs may be required to take prior to writing their license exams. It is likely that bridging programs may not consistently cover the full range of both educational and practice inherent values and behaviours needed to ensure a seamless integration into Canadian work settings. Canadian scholars such as Baumann et al. (2006) and other international authors, such as Daniel, Chamberlain, and Gordon (2001) and Matiti and Taylor (2005), have demonstrated that IENs experience difficulty with different nursing roles, skill sets, and expectations based on how they were trained in their countries of origin. For example, they found that IENs had

some difficulties in practices that ranged from complex dressing changes to taking telephone orders. Blythe and Baumann (2009) attribute these difficulties to variances in the educational preparation of IENs. Considering the different kinds of national bridging initiatives, such as the CARE program in Ontario, IENs are likely to have inconsistent educational preparation in Canada prior to becoming RNs (Health Canada, 2005). This study seeks to inform educational bridging programs of the needs of IENs; highlight their unique practice strengths, which can be utilized to improve patient care and work environments; and inform nursing integration programs at health care institutions.

A significant but distinct perspective to the above communication barriers, given the rising diversity of the patient population, is that having a culturally diverse nursing team would promote the provision of culturally competent nursing care that will meet language and other cultural needs of diverse patients (Matiti & Taylor, 2005; Omeri & Atkins, 2002). Studies that highlight the strengths IENs bring into Canadian work settings and their impact on the provision of culturally competent patient care were lacking. Statistics Canada (2010) projects that “between now and 2031, the foreign-born population of Canada could increase approximately four times faster than the rest of the population” with an increase from “20% in 2006 to between 25% and 28%” in 2010. When IENs are well integrated and their unique contribution to the health care system is fully utilized and supported, they can help create a welcoming environment, one that understands minority patients better, particularly in instances where a patient’s cultural beliefs and practices hinder their communication with health care providers (Yi and Jezewski’s, 2000) study. IENs can also educate their peers about minority patients and lead diversity initiatives to address cultural competence and health equity. Other research involving IENs suggests a need for further studies that examine

how IENs can be fully integrated to promote a healthy work environment (O'Brien-Pallas & Wang, 2006). This thesis study contributes to a comprehensive description of IENs' practice experience and its meaning and highlights how, with effective integration, their unique and diverse contribution can be utilized to enhance the quality of health services delivered.

Situating the Researcher

My interest in this research topic is derived from my personal experience of being an immigrant student in Canada within the Bachelor of Science in Nursing program. Having completed more than ten years of nursing practice in the Canadian health care system, I have had the opportunity to observe first-hand the difficulties experienced by nursing students from immigrant communities during their clinical practicum. As a nursing student who completed her elementary education in a West African nation, I knew that my educational background differed from the rest of my nursing school peers. For example, one difference I encountered occurred when I wrote my first exam in the nursing program. It consisted only of multiple choice questions, but I had been used to a long-answer exam style. This disadvantage, coupled with the fact that I am a visible minority, fortified my will to succeed.

I believed in the value of education for an individual no matter what their background may have been, and I knew that the only way to successfully complete the nursing program and become a nurse in Canada was to adapt to the ways of learning and nursing as taught within the academic program here. Therefore, my interest in this topic was derived from the experiences and challenges I faced in practice settings in Canada, particularly as an immigrant student nurse in a university program.

Furthermore, as a current graduate student, I have become increasingly aware of how knowledge creation strengthens our understanding of concepts and theory. This belief has

served as an impetus for me to examine this under-researched area of nursing practice. Findings from the proposed study will increase nursing knowledge, benefit educators of IENs, and could inspire policy changes. It is for these reasons that making explicit the knowledge of IENs from their own perspective is of utmost importance.

Summary

In summary, drawing attention to the challenges of integrating IENs into their various work settings is vital for developing effective support programs and policies that will ensure patient safety and a healthy work environment. As discussed above, some studies have identified these challenges and areas of improvement such as communication, role expectation (Matiti & Taylor, 2005; Yi & Jezewski, 2000), differences in scope of practice (Blythe & Baumann, 2009; Tregunno et al., 2009), and marginalization (Allan & Larson, 2003; Magnusdottir, 2005; Turriffin et al., 2002). However, there are no Canadian studies that highlight the strengths and expertise IENs bring to the Canadian health care system, which could be beneficial to the provision of culturally competent patient care. Also, studies like that of Tregunno et al. (2009) that proposed a strategy for integrating IENs in a manner that is likely to benefit IENs and their nursing colleagues are few. The proposed study seeks to reduce this knowledge gap, increase the depth of understanding of IENs' experiences within Canadian work settings, and highlight both the strengths IENs bring and areas of improvement at their places of work.

Definition of Key Terms

To facilitate a clear understanding of this research, the following key terms and concepts will be defined:

- Internationally Educated Nurses (IENs): Refers to Registered Nurses (RNs) who have graduated from an international nursing program of study (CIHI, 2010).
- Nursing Regulatory Body: Refers to organizations within “Canadian provinces and territories that establish registration and licensure for RNs [and] determine the eligibility of applicants or members to practice in their jurisdiction” (Canadian Nurses Association [CNA], 2007, p. 9).
- Registered Nurse (RN): A self-regulated health care professional who works autonomously and in collaboration with others, enabling individuals, families, groups, communities, and populations to achieve their optimal level of health (CNA, 2007).
- Registered Practical Nurse (RPN): Also referred to as a Licensed Practical Nurse (LPN), is one of the three categories of regulated nurses in Canada. They are nurses with differences in educational and practice expectations to their RN counterparts (College of Nurses of Ontario [CNO], 2006).
- Licensure: The legislated process through which an RN is authorized to practice, following an assessment of required competencies. Thereafter, the RN may have his or her name and other relevant information entered into the nurses’ register maintained by the regulatory body for nursing in a province or territory (CNA, 2007).
- Support: Refers to the provision of necessary information, assistance, or advocacy to others. Despite the lack of a clear and concise definition of support in the literature, the concept of support consists of both “perceived support” (Cohen & McKay, 1984) and “received support” (Wethington & Kessler, 1986). For

example, perceived support is a conceptualization of resources available (such as a mentor or nursing colleagues) in any clinically stressful situation. Received support moves beyond the perception of available support to an act of support, such as being offered advice. Wethington and Kessler (1986) suggest that both concepts influence one another. In this research, support will involve both perceived and received support.

- Integration: The act of incorporating two or more things, people, or ideas to create something new (Westra & Rodgers, 1991). Westra and Rodgers (1991) identified two levels of integration that will inform this study, namely an abstract and a concrete level. On an abstract level, integration is characterized by, “the merging of two or more elements whereby a newly formed unity is achieved” (p. 1). On a concrete level integration is defined as, “a human-environment interaction whereby new life experiences (such as being an IEN working in Canada) are reconciled with past and present identities and roles” (Westra & Rodgers, 1991, p. 1).

Chapter Two – Literature Review

Introduction

The literature review identified only three research works that provided insight into the lived experience of IENs' professional lives as nurses in Canada, and they all proposed the need for further research in this area. Most of the literature found during the literature review was from the United States (US) and the United Kingdom (UK), with a considerable amount from Australia. Research papers and reports found in the Canadian literature examined IENs' experience with navigating a new health care system, qualification evaluation, and licensure pass rates. However, no Canadian research was located that explored the possibility of IENs as an asset to an increasingly diverse Canadian population. To fill this knowledge gap, the purpose of this study is centred on IENs' integration experience after successfully obtaining their licenses as RNs within the province of Ontario. Due to the descriptive nature of this study and the methodology employed, a theoretical framework was not utilized.

Search Strategy

The literature review was informed by a variety of sources from a number of disciplines to provide context for the study. The review strategy involved searching CINAHL, ERIC, and PUBMED databases for the years 2000 to 2011. Key words and subject headings used for the search were *internationally educated nurse, foreign trained nurse, Canadian nurse, foreign nurse, nurse migration, registered nurse, workplace integration, workplace support, workplace transition, bridging programs, workplace experiences, communication, discrimination, racism, nursing culture, nursing behaviours, nursing role, regulatory bodies, regulatory policies, foreign credentials, credential recognition, and*

nursing licensure. Furthermore, the grey literature was identified by searching the World Wide Web for nursing association websites such as CNA, CNO, Canadian Association of Schools of Nursing, and university program databases, for position papers on internationally educated nurses, their experiences, and integration into Canadian practice settings. In addition, the reference lists and bibliographies of the articles were also hand searched to single out other relevant authors and their work on IENs. The search was limited to English language publications. Key studies published outside the ten year search period were included if they significantly added to the knowledge of IENs and their experiences.

This literature review chapter will begin by situating IEN migration to Western countries, highlighting nurse migration as a global phenomenon with both global and national impacts. Second, IENs' migration to the province of Ontario will be described. Third, the challenges of IENs who immigrate to Western countries, including Canada, as they integrate into their workplaces will be explored. Fourth, the scholarly debates and discourses surrounding IENs' migration will be presented. These debates will highlight ethical implications around nurse migration, contributing elements that influence IENs' nursing practice prior to their immigration to Western countries, such as their nursing training and work experience, as well as a brief description of bridging programs used in preparing IENs for their role as nurses after their immigration. A summary of the literature review will conclude this chapter.

IEN Migration to Western Countries

Recruiting nurses from other nations has become a global practice. In the past few years Western nations including Canada, the US, the UK, and Australia, have recruited nurses from overseas due to nursing shortages. In Canada, the CNA (2002) had projected a

nursing shortage of approximately 78,000 nurses by 2011. In the US, Martiniano, Salsberg, McGinnis, and Krohl (2004) had projected a shortage of approximately one million RN job positions by 2012. Similarly, in Australia a nursing shortage of 40,000 had been predicted by 2010 (Australian Health Ministers' Conference, 2004). Factors such as an aging nursing population, reduced work hours (Buchan, 2006), and a decrease in the allotment of full time university nursing positions (Konno, 2006) have resulted in nations like Canada recruiting nurses internationally to fill job vacancies. Presently, it is unclear if the nursing shortage predictions were accurate in light of CNA's (2009) continued prediction of 60,000 full-time nurse positions by 2022 and the delayed retirement of 22,000 nurses in the year 2011 (Winsten, 2011). In Canada, despite the recent steady increase in the supply of nurses partly due to international recruitment programs, there is growing evidence that the practice of international recruitment will continue if policies remain unchanged (Sochan & Singh, 2007).

IENs in Ontario

Within Canadian provinces, tracking all IENs is a challenge. This is partly because some IENs enter the country as landed immigrants or spouses of landed immigrants through the general class visa (Blythe & Baumann, 2009). CIC (2011) raises the possibility that IENs who enter the country as refugees or through the live-in care giver program do not disclose their nursing status until later. The Province of Ontario is home to 10,850 IENs, representing 11.6% of the nurses in Ontario (CIHI, 2010). This is one of the highest percentages of IENs in the country, with British Columbia (BC) topping the charts at 16.4% and Alberta following at 10% (CIHI, 2010). The IEN population in these three provinces exceeds the national average of 8.3% (CIHI, 2010). In Ontario, IENs are likely to be employed in urban centres (Blyth & Baumann, 2009). The CNO suggests that 18.3% of IENs are between the

ages of 35 to 39 years old, and 12.1% of IENs are 40 to 44 years old. Female IENs in Ontario make up 84.48% of IENs while their male counterparts represent 15.2% (CNO, 2012).

Furthermore, India, Philippines, and the US remain high source nations from which IENs emigrate, representing 35.7%, 16.6%, and 11.8% respectively, in 2012 (CNO, 2012).

From the above picture of IENs in Ontario, one can surmise that not all IENs gain entry into Canada through the Ministry of Citizenship and Immigration's Nominee Program, which includes the nursing profession. The Nominee Program requires the applicant to indicate their nursing status during the initial application process in their home countries (McIntosh et al., 2007). It is more probable that most female IENs had accompanied their spouses who immigrated to Canada through the general class visa entry. This, coupled with the fact that 30.4% of IENs are between the ages of 35 to 44 years old, could support other suggestions in the literature that IENs emigrate for better career prospects, better wages, better quality of life, and family reunion (Aiken, Buchan, Sochalski, Nichols, & Powell, 2004; Baumann, Blythe, Kolotylo, & Underwood, 2004; McGuire & Murphy, 2005; Sochan & Singh, 2007). Within the age group of 35–44 years old, families are usually characterized as having young children and some might assume financial responsibilities for families left behind (Buchan, 2003). This could explain their high determination to gain employment. Blythe and Baumann (2009) state that, "91% of IENs registered with the CNO are employed" (p. 193). It also explains why they immigrate to urban centres (Blythe & Baumann, 2009) where employment is more likely. A comprehensive insight into the experiences of IENs within Canadian work settings could inform integration policies and support program development within educational and health care institutions. This

development can positively enhance their transition as nurses by increasing their confidence to provide safe care and promote their integration as part of the health care team.

Nursing Practice Challenges IENs Face at their Workplaces

Comprehensive insight into the experiences of IENs is valuable for informing efficient integration programs within Western work contexts. This section will present within three main themes some challenges IENs face at their places of work, identified from studies in the field, namely: a) language and communication barriers; b) cultural influences and role expectations; and, c) marginalization. In addition, scholarly debates and discourses surrounding IEN migration that are likely to influence IENs' integration into health care systems in the West, such as the nursing training from their home countries and the role of bridging programs, will be briefly described.

Language and communication barriers.

Analysis of the literature suggests that the majority of IENs who face language and communication challenges are from visible minority groups who speak English as a second language and who come from countries in Africa, the Middle-East, Asia, and Eastern Europe (Alexis & Vydelingum, 2004; O'Brien-Pallas & Wang, 2006; Omeri & Atkins, 2002; Polsky, Ross, Brush, & Sochalski, 2007; Tregunno et al., 2009; Withers & Snowball, 2003). For many IENs, English is not their mother tongue. In health care settings involving patient care and service delivery, proper and timely communication is vital for quality care provision (Tregunno, Jeffs, & Campbell, 2007). Ineffective communication and language barriers create hindrances to IENs' performance of their nursing responsibilities and could result in them being blamed for errors as a result of their inability to communicate efficiently (Yi & Jezewski, 2000). One participant stated, "If you cannot talk, then you cannot defend

yourself" (Yi & Jezewski, 2000, p. 724). Communicating pertinent patient information to other nurses, members of the multidisciplinary team, and even to patients in a timely manner assures the smooth delivery of patient care. An inability to communicate seamlessly regarding care provided to patients can leave IENs feeling humiliated and all other team members, including IENs and patients, feeling frustrated (Alexis & Vydelingum, 2004; Bola, Driggers, Dunlap, & Ebersole, 2003).

Furthermore, language and communication barriers also involve non-verbal communication obstacles that can convolute nursing tasks and interactions for IENs (Bola et al., 2003; Konno, 2006; Magnusdottir, 2005; Matiti & Taylor, 2005; Sochan & Singh, 2007; Tregunno et al., 2009; Withers & Snowball, 2003; Xu, 2007; Yi & Jezewski, 2000). For example, Bola et al. (2003) reported differences in how IENs and host nurses in the US approached patients. The authors stated, "Nonverbal communication that differs from the established norms may be interpreted as inattentive, subservient, or disrespectful" (p. 40). Bola et al. further describe that differences in cultural norms can influence how nonverbal cues are interpreted. The authors illustrated this difference by conceptualizing culture as either being "high context" or "low context". High context cultures will attach greater meaning to nonverbal communication cues such as eye contact, and low context cultures will attach lesser meaning to nonverbal cues and more to words. Yi and Jezewski's (2000) qualitative study, using grounded theory methodology, involving 12 Korean nurses, had similar findings regarding the interpretation of cultural norms while interacting with patients or their nursing colleagues. In their study, participants seemed distressed during interactions in which non-verbal cues were difficult to assess, such as in a telephone conversation. For example, when involved in phone conversations, IENs felt anxious, nervous, and

embarrassed by not being able to perceive others' reactions to their communication abilities (Yi & Jezewski, 2000). Even though these nurses may be knowledge experts in their areas of nursing, differences in non-verbal communication cues may result in struggles that can hinder their effective integration into their new areas of work in Western settings.

A distinct perspective regarding the non-verbal cues identified as problematic in the work environment is that such non-verbal cues can be a positive attribute, particularly when working with diversified patient populations (Matiti & Taylor, 2005; Withers & Snowball, 2003; Yi & Jezewski, 2000). Limited exposure to other cultural norms can create unfavourable work conditions for the nurses involved, and also for patients who share similar cultural values (Matiti & Taylor, 2005). In Matiti and Taylor's qualitative study using phenomenological traditions, the authors noted that challenges with effective communication, resulting from accents and the use of colloquial language, "seem to be a two-way communication problem" (p. 13). Castledine (2000, as cited in Matiti & Taylor, 2005) argues that "patients are often confronted with these variations daily, yet no one talks about them" (Matiti & Taylor, 2005, p. 13). For example, when Caucasian Canadian nurses are faced with patients from visible minority backgrounds, who may have distinct cultural norms including more non-verbal communication, such as eye contact or silence, having an IEN with a similar background as the visible minority patient may provide a more welcoming atmosphere for the patient. Additionally, the visible minority patient can also be faced with difficulties in understanding the Caucasian Canadian nurse during communication. Etowa's (2007) qualitative study, using a grounded theory methodological approach involving 20 Black nurses in a Canadian province, demonstrated the value of better integration policies in health care settings at various levels. Etowa's study suggests that integrating IENs from

different racial backgrounds promotes a culturally diverse workforce that can improve access to appropriate and culturally sensitive health care service for patients from different racial backgrounds. Other studies have suggested that IENs feel more at ease when they encounter nursing staff from the same background (Konno, 2006; Withers & Snowball, 2003). Noted in Withers and Snowball's (2003) study, participants expressed their preferences to socialize and speak in their own language in their work settings, stating, "My friend and I were talking in the Filipino language but we were told to talk English. We miss our language, that's why we talk it" (p. 286). More Canadian studies that explain how the strengths of IENs can contribute to patient care, especially in an increasingly diversified patient population, are required.

Given the verbal and non-verbal communication challenges IENs face, it can be assumed that communication extends beyond IENs' capability to speak English with their patients and colleagues. They must be familiar with the health care, organizational, and cultural contexts of Canadian society in order to function efficiently in the system. IENs must also have a good understanding of medical terminology, including prefixes, and suffixes of certain medical terminology. According to Bola et al. (2003), "The differences in medical terminology, abbreviations, jargon, medical names, suffixes, and prefixes – even the names of common items can pose a significant limitation for these nurses" (p. 40). Other authors like Withers and Snowball (2003), report similar findings. IENs are expected to communicate patient status and the level of care provided during verbal report to other nurses, team members, and patients on issues such as laboratory results or other aspects of care. An inability to comprehend and communicate in a competent fashion could be problematic, particularly in an unforeseen situation, such as changing patient status. In Canada, Tregunno

et al. (2009) confirm the language and communication challenges faced by IENs, indicating that IENs encounter stress resulting from their inability to understand others and “require frequent repetition” (Tregunno et al., 2009; p. 187). Comprehensive support programs that facilitate IENs' effective integration into Canadian work settings are important. This thesis seeks to inform the creation of such valuable programs.

Matiti and Taylor (2005) identified a contrasting perspective to the challenges IENs encounter with medical terminology. In their phenomenological study involving 12 nurses, they found that IENs who worked in Operating Rooms (ORs) credited their ease with communicating and integration into their new workplaces to the universal names of procedures and instruments used in any OR. Furthermore, non-verbal communication using eye contact over surgical masks was found to be easily interpreted because participants in this study, by experience, could anticipate what the surgeon's non-verbal cues meant (Matiti & Taylor, 2005). Their study highlights the value IENs can bring to the Canadian health care system when integrated in areas that can take into account their work expertise and experience. IENs' difficulties with medical terminology and suffixes could be suggestive of variances in nursing educational preparation in their various home countries (Blythe & Beaumann, 2009), health conditions identifiable in different nations (Bola et al., 2003), health care systems (Buchan, 2006), and practice contexts. More studies that examine IENs' professional practices and how they could best be integrated into the Canadian health care system are valuable. This information could minimize the detrimental effects of language barriers, and ineffective verbal and non-verbal communication on patients, their families, and the health care team.

Cultural influences and role expectations.

IENs immigrate to Canada and other Western nations from diverse cultural backgrounds, which could be reflected in their nursing practice, as well as in their beliefs and values about nursing (Leininger, 1970). Even though some IENs migrate between Western countries, like the US and Canada, most of the literature on this subject indicates that IENs from visible minorities and cultural backgrounds are likely to face identified challenges during their transition. Matiti and Taylor (2005) suggest that the way IENs think about their own cultural influences (“primary culture”) and those of their host countries (“secondary culture”) together determine their integration into their new practice settings (p. 10). An example of a primary cultural influence is illustrated by methods of interaction, such as avoiding eye contact when approaching a patient or patient’s family (Yi & Jezewski, 2000). Such cultural norms may be different from Western cultural standards, which expect eye contact during interaction.

Differences in nursing practice and role expectations suggest a lack of comprehensive support programs, which are essential for cultural considerations and to help IENs adapt to Canadian nursing standards. An understanding of underlying cultural influences within support programs for IENs can ease their transition in practice settings.

The expectation of practice for nurses in Canada generally, and in Ontario in particular, is inclusive of their role and scope of practice as nurses. For IENs, certain aspects of the nursing role as well as their scope of practice often differ greatly from what they encounter in their countries of origin. For example, Daniel et al.’s (2001) qualitative study illustrates how study participants from the Philippines found nurses in the UK to be involved in basic nursing care. They explained that participants “were used to having relatives at the

patient's bedside that would assist with care, including feeding, washing, and turning" (p. 260). Certain characteristics and actions by nurses are utilized to describe and define the nurses' abilities. Nurses are expected to be assertive in decision-making related to patient care and well-being within collaborative care team scenarios. Differences in role expectations and scope of practice from host countries and countries of origin have been identified as an area of practice challenges for IENs, particularly those who have immigrated from racially diverse nations (Daniel et al., 2001; Konno, 2006; Tregunno et al., 2009; Withers & Snowball, 2003; Yi & Jezewski, 2000). For example, a nurse advocating for his or her patient must demonstrate a measure of assertiveness. In Withers and Snowball's (2003) qualitative study, a lack of assertiveness can be attributed to differences in practice norms. This is exemplified in participant responses like, "At home, decisions are only made by doctors, I like nursing here because of being the patients' advocate, there is evidence-based practice and the doctors listen, in the Philippines the consultant is god" (Withers & Snowball, 2003 p. 284). In another instance, participants stated, "Nurses are very aggressive here; not like the Philippines where you just follow what the doctors said" (Withers & Snowball, 2003 p. 284). Konno's (2006) systematic review on qualitative studies that examined IEN adjustment into Western settings cited scholars, like Jackson (1996), who made similar suggestions. In Jackson's study, participants state, "At work, many girls will argue with men and sometimes I am expected to argue with men like doctors too, but at home, I cannot argue with my husband, it is different for us" (p. 122). Yi and Jezewski's (2000) examination of Korean nurses' adjustment to hospital settings in the U.S., illustrates that they expected family members to provide assistance with personal care to the patients, as is commonly done in Korea. The authors stated, "Because family members stay with patients in Korean hospitals

and provide most of the bedside nursing care, such as bathing and feeding, Korean nurses were puzzled, confused and frustrated when they saw that family members rarely do so in the USA” (Yi & Jezewski, 2000, p. 725). Additionally, participants in this study interpreted assertiveness as being able to speak up to defend themselves to their colleagues and patients. For example, participants stated, “Here in America ... people solve problems with talk, however, Korean nurses solve problems with direct work almost all the time” (p. 726).

Literature in the field has also shown that IENs discover that the nursing roles in Western nations come with more responsibility and accountability, which they were not used to in their countries of origin. For example, nurses in Western nations assume more responsibility for promoting patient self-care and for their nursing actions (Daniel et al., 2001; Winkelmann-Gleed & Seeley, 2005; Xu, 2007). In Xu’s (2007) metasynthesis of qualitative studies of IENs and their integration, the experiences of immigrant Asian nurses were examined. Asian nurses discovered that legal structures around nursing actions differed, for example, more emphasis is placed on documentation of care. In addition, nurses in Western nations were legally responsible for their nursing actions, even if ordered by physicians. For example, nurses in Western nations are liable for medication errors involving dosages despite the existence of a written order from a physician. Most IENs come from health care environments where professional hierarchy and dominance is more evident (Tregunno et al., 2009). As a result, questioning physician orders is uncommon. Such differences in nursing role expectations and scope of practice within Western work settings require supportive integration programs for IENs coming from different care contexts, to enhance patient safety.

In contrast, a welcoming and inclusive work environment that can benefit both IENs and patients with whom they share a similar background can be promoted when other cultural norms and behaviours are well understood (Alexis & Vydelingum, 2004). Knowledge of other cultural norms and behaviours can influence how the majority of Canadian nurses interpret and react towards IENs' practice expectations at their workplaces. O'Brien-Pallas and Wang's (2006) report suggests that IENs are likely to rate team practices at their workplaces as average or poor. For example, the authors state that "emotional abuse for the internationally-born nurses compared to the Canadian nurse was significantly more often from the patient or client or resident, depending on the environment in which they worked and from nursing coworkers" (p. 54s). Healthy work environments are likely to contribute to IEN retention within the nursing profession. Similarly, healthy work environments can allow IENs to become resourceful workers along with their Canadian nursing colleagues in the provision of transcultural care to all Canadians. Matiti and Taylor (2005) suggest that primary and secondary cultural customs, which both influence nursing actions, can be learned in nursing programs. An understanding of these cultural differences can inform how support programs for IENs are built to ensure an effective integration into Western nursing settings.

Additionally, Davitz, Davitz, and Sameshima (1976) note that when IENs come to practice nursing in Western countries, they would prefer to practice as they have been trained in their countries of origin but such nursing approaches are likely not to be informed by scientific and best practice evidence and guidelines. Within the Canadian nursing practice context, the use of evidence-based practices and guidelines is common (CNO, 2002). Unfamiliarity with such standards is likely to create practice and integration challenges for

IENs within their work settings. Nursing practice guidelines are cultural norms distinguishable to Western nursing practice cultures and environments. Their creation, uptake, and dissemination amongst nurses and nursing communities are taught as part of professional standards. Coming from nations that are unfamiliar with such practice standards, or that do not have practice environments that reflect such considerations, can hinder IENs' integration into these work settings. This buttresses Xu and Zhang's (2005) proposition that one size does not always fit all.

Not only do cultural values influence the nursing practices of IENs, they also shape their interactions, communications with and responses to patients, nurses, and other professional team members of the host countries (Omeri & Atkins, 2002). Comprehensive support programs and policies that reflect cultural considerations are likely to minimize negative personal and professional experiences faced by IENs as they navigate within the Canadian practice context.

Marginalization.

Inefficient integration programs that lack comprehensive support structures for IENs as they integrate into Canadian work settings are likely to leave them with sub-standard attitudes towards their colleagues and workplaces (Alexis & Vydelingum, 2005; O'Brien-Pallas & Wang, 2006). Studies and related reports on this subject that have examined IENs both in Canada and internationally suggest that IENs feel discriminated against in their various work settings (Hagey et al., 2001; O'Brien-Pallas & Wang, 2006; Omeri & Atkins, 2002; Tregunno et al., 2009; Turriffin et al., 2002). Even though the feelings and experiences of being discriminated against reported by IENs in various studies are anecdotal, they appear to be universally consistent. For example, Turriffin et al. (2002) examined nine immigrant

nurses' experiences while integrating into new work settings in Canada by using an interpretive qualitative approach based on Essed's (1991) work. In this study, participants reported feeling as "other," especially when their assigned patients refused their care. Similarly, Hagey et al.'s (2001) descriptive exploratory study involving nine Black nurses in Ontario revealed the prevalence of racism, and her study participants had filed formal complaints of racism against their employers. Hagey et al. argued that "intercultural matters cannot be effectively dealt with without examining racism and inequity in the workplace and in professional and educational institutions" (p. 393). It is notable that in both of these Canadian studies the IENs reported being reprimanded after complaints were forwarded to their respective supervisors.

In Omeri and Atkins's (2002) qualitative study using phenomenology, involving five participants, feelings of loneliness and the sense of being the "other" was reported by study participants. They attributed their marginalization to their identity, ethnicity, and experience. For example, they stated, "Most people I came in contact with did not have any knowledge of different people from different backgrounds. They were treating me like I was stupid, that I was from a third world country. It was not nice" (p. 502).

IENs also seem to experience discrimination in relation to their career advancement. Compared to their Caucasian counterparts, IENs experienced more limitations and difficulties in obtaining time to further their education (Hagey et al., 2001; O'Brien-Pallas & Wang, 2006). IENs felt their supervisors discouraged their pursuits to advance their education and career, especially if the IEN had non-work related responsibilities, such as caring for multiple children, a husband, or overseeing the smooth running of their homes (O'Brien-Pallas & Wang, 2006). Unequal career treatment is also reflected in international

studies where IENs were convinced that race or skin color determined what career position they occupied (DiCicco-Bloom, 2004). In DiCicco-Bloom's (2004) qualitative study, one participant attributed unequal career treatment, despite her qualifying certifications and numerous nominations for nurse of the year, to racism stating, "the supervisor - he is a white man - he told one of the people I work with that he does not trust people who were educated outside this country" (p. 31). Similarly, a UK study of IENs revealed that discrimination is a common experience (Allan & Larsen, 2003). Study participants felt discriminated against by being assigned unfavourable hours of work, and felt that increased work scrutiny and bullying from their colleagues occurred because they looked or sounded different from the majority of the other nurses (Allan & Larsen, 2003). These kinds of experiences negatively influence IENs' integration into their various work settings, and often lead to feelings of isolation and frustration. Meleis (2003) suggests that events that make disadvantaged groups, such as IENs in new practice environments, recall being different are likely to increase their feelings of vulnerability.

Marginalization practices appear to be more prevalent in social professions, such as nursing, where distinction and professional hierarchy are present (Hall, Stevens, & Meleis, 1994). For example, depending on the work environment, a nursing team could consist of an RN, an RPN, a nurse manager, and an Advanced Practice Nurse (APN). These nurses could further be characterized by various ethnic backgrounds. Hall et al. (1994) describes marginalization as "the process through which persons are peripheralised on the basis of their identities, associations, experiences, and environments" (p. 25). From this definition, one could describe IENs as being different from other nurses based on their racial background. Similarly, Etowa, Sarla, and Thompson-Isherwood's (2009) qualitative study involving 20

Black nurses highlights the issue of marginalization within a theoretical lens of Black nurses' experiences at their workplaces. Within the "surviving the margins theory" (Etowa et al., 2009), participants reported feelings of insecurity and isolation at the workplace as a result of being in the margins. This is demonstrated by one participant's verbatim report stating, "It is very challenging and it is isolating to be a Black nurse in a white majority setting" (p. 176).

Within the nursing profession, distinctions are further enhanced by qualifications and positions that create and sustain distinct boundaries (Hall et al., 1994). An IEN occupying a new position in a new work environment and country, who sounds and looks different from the majority of nurses, could fit into the above-described criteria. Negative professional experiences such as bullying, disrespect, and work scrutiny (Allan & Larsen, 2003), lack of skill development opportunities (Alexis & Vydelingum, 2005), power dominance reflected through the fear of revenge when complaints about racist actions are filed (Hagey et al., 2001), and lack of promotional opportunities are all consequences associated with being different (DiCicco-Bloom, 2004; Winkelmann-Gleed & Seeley, 2005). These may place IENs at a disadvantage – at the margins of their workplaces (Etowa et al., 2009). This could hinder their full contribution to patient care and the nursing profession. A good understanding of such hindrances can facilitate the creation of appropriate support policies and programs for IENs as they integrate within various practice settings. Support policies and programs can facilitate the reduction of institutional racism that is "reproduced through personal, interpersonal as well as structured social relationships" (Allan, Larsen, Bryan, & Smith, 2004, p. 124).

Scholarly Debates and Discourse

This section of the literature review will present current debate and points of interest around IEN migration from an individual and governmental context, which has the potential to further problematize the issue of nurse migration and their effective integration. These debates and scholarly discourses include ethical implications of IEN migration, IENs' nursing training in their home countries, and the role of bridging programs.

Ethical implications of IEN migration.

Debate is growing over the ethical implications involved in recruiting IENs to occupy nursing positions in Western nations (Buchan, 2006; Kingma, 2007; Kline, 2003; Xu & Zhang, 2005). Xu and Zhang (2005) state that ethical standpoints are likely to result from different interest positions, which the authors described as, "individual level (nurse), institutional level (health care agency), national level (country), and international level (international relations)" (p. 572). For example, an ethical dilemma may arise when experienced nursing personnel in nations with struggling health care systems, low income levels (Buchan et al., 2003), or sub-optimal standards of living (Singh, Nkala, Amuah, Mehta, & Ahmad, 2003) are recruited to work in developed nations with better work opportunities, conditions, and wages (Aiken et al., 2004). Such recruitments results in significant nursing shortage within the under-developed nations (Perrin, Hagopian, Sales, & Huang, 2007), however, the mobility rights of the individual cannot be constrained (Buchan, 2006). An ethical debate then ensues over the right to deplete essential nursing personnel versus providing these nurses the opportunity for self-advancement. Similarly, on an institutional level, the ethical debate lies in the appropriateness of creating a nursing shortage situation within hospitals in

developing nations by recruiting their nurses to fill nursing positions in Western nations, like Canada.

There are no unified positions on the international recruitment of nurses, particularly since migration seems to be influenced by broader social determinants of health factors such as better income and quality of life. Ethical debates are noticeable when nursing recruitment originates from African nations (Kingma, 2007), and subtler with other nations including the Philippines and India (Marsh & Loudon, 2013) where recruiting agreements exist between these nations and the UK. Other recruiting patterns are apparent with other Western countries recruiting amongst themselves. For example, Australia recruits nurses from the UK (Buchan, 2006). In fact, Perrin et al.'s study (2007) showed that recruiting nurses from the Philippines leaves significant problems resulting from local nursing shortages in government and private hospitals despite the existence of recruiting agreements. Further, the presence of recruiting agreements between the UK and the Philippines, for example, is likely to create situations where new graduates from the Philippines seek Western employment opportunities without adequate nursing experience (Perrin et al., 2007). Additionally, nurse administrators are reluctant to invest in resources to train new graduates who may later leave for better career opportunities in the West (Perrin et al., 2007). This reluctance can result in scenarios where nurse graduates lack adequate nursing work experience and exposure to different patient conditions.

Some literature suggests initiating the IENs' recruitment and credential evaluation process in their host countries (Singh & Sochan, 2010; Tregunno et al., 2009). One would anticipate such practices to be beneficial to all stakeholders if accompanied by more accountable policies, such as using international employment statistics (Pang, Lansang, &

Haines, 2002) to estimate how many IENs leave their host countries through international recruitment. To promote transparent and consistent educational and professional standards, which in turn promote consistent cultural, behavioural, and practice characteristics, policies should be encouraged between countries with hiring agreements, such as instituting clinical practice exchange programs within the curriculum. For example, Baumann et al. (2004) suggest that in some source countries curriculum differences, like an increased emphasis in one nursing specialty, such as obstetrics, and less in other nursing areas like psychiatry, may exist. This lack results in some IENs requiring substantial educational upgrading upon arrival in Canada, or other Western work environments. Even though educational upgrading may not equate to an easier transition for IENs into their new work settings, it may potentially give them an idea of what they are likely to experience if they choose to relocate to the West.

IENs' Nursing Training in their Home Countries

In this section of the literature review I will present an overview of studies that have examined IEN training in their home countries. This is a key element that influences their nursing practice after relocation to Western countries.

IENs that migrate to Western countries do so after obtaining their nursing training in their home countries. I will briefly state a number of factors that contribute to their migration to add more depth to my discussion on the proficiency of centers that train some IENs. According to literature in the field, reasons for IEN migration have included socio-economic factors such as: poor career prospects for them in their own countries, economic instability (Aiken et al., 2004), better-quality information and communication technology (Kingma, 2001), superior career paths, higher wages, and an elevated quality of life (Aiken et al., 2004; Hawthorne, 2001; Konno, 2006; Meyer, Kaplan, & Charum, 2001). In relation to their

nursing training, however, political factors are also influential, such as government policies which encourage work exchange migration (Armstrong, 2003; Buchan et al., 2003). Through these government settlement programs, nations like the Philippines train larger numbers of nurses than they are able to hire in order to export them. One would question whether the intent of such educational training programs in these nations is geared towards patient safety and patient-centred care within Western health care contexts, and also towards nursing professional advancement, or for individual and corporate financial gain.

The possibility of training inconsistencies in other countries highlights the need for effective integration programs in Western countries that recruit IENs. For example, Hall (2005) suggests that every community of nursing has its own culture, which is demonstrated by unique values and behaviours. Such behaviours are probably influenced by educational preparation (Blythe & Baumann, 2009). Bohnen and Balantac's (1994) landmark study showed that nurses are trained to meet the health needs of patients in their countries by using unique patient illness situations and technology. Similarly, Bola et al. (2003) suggest IEN training is influenced by health care conditions in their various nations. Therefore, expecting an IEN from a completely different nation characterized by possibly different illness conditions and prevalence, culture, and education preparation to fit into another society is unrealistic. There are rising numbers of studies that suggest IENs face nursing practice challenges due to differences in communication and role expectation at their workplaces (Blythe & Baumann, 2009; Bola et al., 2003; O'Brien-Pallas & Wang, 2006; Tregunno et al., 2009). The need for policy creation which extends beyond gaining entry into Canada or obtaining RN licensure (Singh & Sochan, 2010) to policy that is broadened to facilitate IENs' integration into various practice settings in ways that will highlight their expertise, is

vital so that patients and safe practice standards are not neglected. More studies that provide comprehensive findings on the experiences of IENs within Canadian work settings can help inform such policy reform efforts, which would help ensure that the sizeable number of IENs who immigrate through work programs other than nursing have a better transition into the Canadian health care system.

Despite the existence of recognized educational bridging centres (Xu & Zhang, 2005), IENs still require a remarkable amount of support with basic behavioural attributes pertinent to the Canadian ways of providing care. For example, in Tregunno et al.'s (2009) study, IENs from the Philippines found that nursing practices, such as consulting patients and their families before decisions about their care are made, to be novel. To illustrate such differences, one participant stated, "The doctor in the Philippines decides pretty much everything, I am [the doctor] the boss, I am going to tell you what to do. But here, one cannot function without the other...which is a good thing" (p. 186). Furthermore, to demonstrate differences in scope of practice, one IEN in this study said, "At home...it's more like, you just follow orders...we never learned to listen to chests or something like that...all these things are done by the doctor there" (p. 186). Many of these attributes can be enacted within a patient-nurse therapeutic relationship along with collaboration amongst professional teams. For IENs to have the appropriate support and training needed to promote their integration into practice settings in Canada, more comprehensive studies that will inform such training and support programs are needed. The proposed research seeks to contribute to this need.

Bridging Programs

Despite a clear need for efficient educational programs for IENs within Canadian practice settings, the amount of existing literature evaluating or describing such bridging

programs for IENs in Canada is scarce. Zizzo and Xu's (2009) systematic review on transitional programs for IENs suggest there are few studies that evaluate the effectiveness of current bridging programs for IENs. Two studies by Adeniran et al. (2007) and Yahes and Dunn (1996) that evaluate IENs' bridging programs in the US exist, five studies were identified in the UK (Gerrish & Griffith, 2004; Horner, 2004; Parry & Lipp, 2006; Winkelmann-Gleed & Seeley, 2005; Witchell & Osuch, 2002), and in Australia, two studies and one report were identified (International Institute for Policy and Administrative Studies [IIPAS], 1990; Menon, 1992; Palmer, 1989). In the UK, bridging programs for IENs who come into the country are a governmental requirement (Zizzo & Xu, 2009). Recruiting and licensing policies for IENs need to extend considerably within practice settings through integration programs which ensure that as IENs fill nursing positions in Western nations, they do so efficiently with minimum compromises to patient safety, positive work environments, and quality of care. Zizzo and Xu suggest that the limited amount of research which evaluates transition programs for IENs, as well as their inconsistencies, may be due to "limited funding or expertise, lack of institutional and managerial commitment, or a misconception that IENs do not have unique transitional and adaptation needs" (p. 61). More in-depth studies that examine the experiences of IENs as they integrate into Canadian work settings are likely to inform the necessary support policies, and integration programs within both practice settings and the community that can facilitate IEN transition and support their integration into the Canadian health care system.

Summary

Nursing has become a global profession in which nurses coming from different health care contexts, with varying educational backgrounds and professional and cultural values, are

relocated to different work and cultural contexts. Scholars in the field suggest factors influencing the integration of IENs include language and communication barriers, cultural influences, differences in educational preparation, various role expectations and nursing scopes of practice, and effects of racism and marginalization. Buchan (2006) stated that the challenge for Western nations is to “ensure that migrant nurses receive equal treatment to home-based nurses” (p. 22s).

The above synthesis of literature suggests that IENs struggle in their new work settings even after obtaining their licenses to practice as RNs in Canada and other Western nations. This points to a need for studies that explore the issues influencing IENs' integration experiences from the perspective of the IENs themselves. This Master of Nursing thesis which examined IENs' experiences of working in the province of Ontario's health care system has contributed to the body of Canadian literature which is necessary for effective workplace and diversity program development. Findings of this study may inform the development of integration programs that may promote safe work environments and collegial work relationships among nursing colleagues. It may also inform international recruiting policies of the need to extend into practice settings through comprehensive support program development to facilitate the integration of IENs into the Canadian health care system. The next chapter will present the research methodology.

Chapter Three – Research Methodology

The purpose of this chapter is to outline the methodology used to guide this study, which seeks to critically examine the experience of IENs as Canadian RNs during their first five years of practice in Ontario's health care system. Descriptive phenomenology, a qualitative research method, is the chosen research approach for this study. The chapter will begin with a definition of qualitative research. Second, I will present descriptive phenomenology as the chosen methodology and research tradition for this study, including its historical roots, philosophical foundations, and its suitability for this research. Third, I will describe the ethical considerations of the study, including the process of informed consent. Fourth, various aspects of the study's research design, such as sampling method and size, study setting, data collection, and data analysis will be presented. The chapter will conclude with the various strategies employed to ensure the trustworthiness of the data generated in this study.

Qualitative Research

This study is guided by philosophical underpinnings of qualitative inquiry using the traditions of descriptive phenomenology. Creswell (2007) describes qualitative research as assumptions, a worldview, the possible use of a theoretical lens, and the study of research problems inquiring into the meaning individuals or groups ascribe to a social or human problem. To study a problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data takes place in a natural setting and is sensitive to the people under study, and data analysis is inductive, which often results in establishing patterns or themes from the data. The final written report or presentation includes the voices of participants, the reflexivity of the researcher, and a complex description and interpretation of

the problem and it extends the literature or signals a call for action (Creswell, 2007). Thus, by using a qualitative research approach, an in-depth understanding and meaning of a phenomenon can be accessed by the researcher.

Creswell (2007, p. 21) describes five philosophical assumptions of qualitative research as follows: a) the ontological assumption (nature of reality) that encompasses multiple realities of both the “study participants and the readers of qualitative research”; b) the epistemological assumption (relationship between the researcher and the study participants), which describes the “subjective evidence assembled based on individual views; first-hand information”, and is facilitated by the researcher’s attempt to get closer with the study participants in an attempt to know them; c) the axiological assumption (role of value) acknowledges the values the researcher brings to the research; d) methodology as the process of research (the researcher’s inductive reasoning); and, e) methodology as the language of research, which describes “the study within its context”.

My decision to choose qualitative research methodology arises from the variety of study designs unique to this method of inquiry. Qualitative methodology is suitable due to the descriptive nature of my study question, which examined the integration experiences of IEN as nurses in Canada, and what meaning they ascribe to their experiences. This methodology allowed me to get close to the participants and to get multiple viewpoints that contributed to the richness of the data collected. This methodology also allowed for the emergence of themes through inductive reasoning throughout the research process. In the next section, I will present descriptive phenomenology, the research tradition used in this study.

Descriptive Phenomenology

Descriptive phenomenology, a qualitative research approach founded by Husserl (1859-1938), is defined as “the science of essence of consciousness” (Husserl, 1913). Wojnar and Swanson (2007) define descriptive phenomenology as, “how objects are constituted in pure consciousness, setting aside questions of any relationship of the phenomenon to the world in which one lives” (p. 173). It entails examining how objects or experiences are consciously represented by those who go through it. Vital to the Husserlian precept of descriptive phenomenology as a scientific approach is the belief that the meaning of lived experiences can be uncovered through interactions between the researcher and the participants of the research study, “the objects”. According to Husserl (1913), in order to have a superior depiction of what reality is to the participant, the researcher must use active listening, interaction, and observation of the participant.

Philosophical Foundations of Descriptive Phenomenology

Philosophical assumptions about how descriptive phenomenology can be conducted as a science include: a) our neutrality as we interact with conscious human beings; b) that there are commonalities, “essences”, of lived experience between all persons who have lived that same experience; and, c) the researcher’s interaction with the objects (Husserl, 1913).

According to Husserl (1913), a philosophical assumption of descriptive phenomenology involves interactions with conscious human beings. Our perceived experiences are value-laden, and ought to be objects of scientific inquiry. Consistent with Husserl’s belief is that subjective human facts are significant to researchers who strive to understand human reasoning. Within this lens, researchers are recommended to be open and neutral to the realities of their objects, a state described as “transcendental subjectivity”

(Lopez & Willis, 2004, p. 727). For example, by studying IENs' experiences using this research approach, I can generate information about their perceptions of reality in the Ontario health care system and how that impacts on their description of a successful integration and ultimately patient care. Husserl suggests that as humans, our perceptions of reality contribute to our actions or inactions. In this regard, an IEN's perception of reality can determine whether or not they readily seek assistance from their nursing colleagues.

A vital component of Husserl's (1970) descriptive phenomenology relates to the researcher conducting the study. Husserl claimed that in order for researchers to use the descriptive phenomenological approach and minimize bias, it is necessary to consciously eliminate all prior knowledge about the phenomenon at hand by effective bracketing. Bracketing is described as a conscious attempt to set aside all personal biases and experiential knowledge so that they have no influence on the final description of the phenomenon (Tymieniecka, 2003). This distancing will enable the researcher to grasp the true essence of the subjects lived experiences. Lopez and Willis (2004) suggest that "the goal of the researcher is to achieve transcendental subjectivity (a Husserlian concept) through bracketing (p. 727). Similarly, Wojnar and Swanson (2007) propose that literature in the field can act as a source to "neutralize personal bias" (p. 173). There are debates about not performing a literature review prior to the research (Deutscher, 2001) to maintain a neutral stance as a researcher. On the other hand, a literature review notwithstanding, scholars like Swanson-Kauffman (1986) claim the effects of personal experiences cannot be ignored. Through bracketing, the researcher can attain neutrality by constantly assessing and documenting oneself for biases and the impact that preconceived notions may have on the current research data. These preconceived notions may be obtained from undertaking a

literature review or from any other prior knowledge about the phenomenon under study. The process of bracketing involves a reflection – being aware of and taking control over preconceptions, and personal knowledge when interacting with study participants and when interacting with the data collected (LeVasseur, 2003) For example, in the proposed study, my literature search was performed mainly to illustrate the present gaps in the field, and the lack of a clear conceptualization of IEN experiences within their various workplaces. Also, to neutralize my previous views about the experiences of IENs in the Canadian health care system. Bracketing, when effectively performed, ensures the generation of rigorous scientific data in its pure form (Polit & Beck, 2008). Bracketing was enacted throughout this study by my continual journaling activities to eliminate any prior opinions, knowledge, or biases about IENs and their experiences.

Another philosophical assumption underpinning Husserl's approach of descriptive phenomenology is that there are commonalities with lived experiences between all persons who have lived that same experience. Natanson (1973) describes these commonalities as the essences of the lived experience and, according to him; they symbolize the true description of the experience being studied. Likewise, I analyzed the data to extract major themes and validated the meanings of my interpretation of IENs' stories with participants throughout the research. In keeping with the principles of descriptive phenomenology, the IENs' reality is captured through the common themes or essences identified; this is considered independent of the context within which it occurs (Lopez & Willis, 2004). The identified essences enabled the conception of generalized descriptors of IENs' experiences within Ontario work contexts (Lopez & Willis, 2004; Luft, 2003).

Effective bracketing allowed me, as the researcher, to handle the data in a wholesome way. Wojnar and Swanson (2007) describe the process of bracketing as involving three steps: a) separating the phenomenon from the world and inspecting it; b) dissecting the phenomenon to unravel the structure, define, and analyze it; and, c) suspending all preconceptions regarding the phenomenon (p. 173).

As the primary researcher of this study, I followed through with Wojnar and Swanson's (2007) steps by first carefully examining the data to ensure accurate interpretation of the issues discussed. I analyzed the data in order to identify and extract major themes and categories considered by the participants to be true and independent of the context within which these experiences occurred. These truths are described as the essences central to the phenomena of the thesis study (Husserl, 1913; Lopez & Willis, 2004), and reflect the rigorous and scientific elements pertaining to this methodology. Second, I organized the themes and patterns from the data in ways that captured the essence and structure of the phenomenon under study. In this analysis phase, which Wojnar and Swanson describe as "dissecting the phenomenon" (p. 173), the researcher clarifies the meanings of each significant statement, word, or category and then re-organizes them into groups. This strategy is in line with Colaizzi (1978), who suggests organizing meanings into groups of themes. Recurring actions, whereby as the primary researcher I presented the identified groups of themes in order to validate their meaning to the participants, occurred throughout the analytic process. Third, I performed reflexive journaling prior to, and throughout, the data collection process, facilitating the identification and control of preconceived opinions and beliefs about IENs and their experiences. Such preconceived ideas or beliefs could be initiated while performing a literature review.

In addition to the analysis, I kept personal notes during the reflexive journaling process and throughout the validation process in order to identify any discrepancies amongst identified themes. Finally, an incorporation of identified themes and categories into comprehensive descriptors of IENs' integration experiences took place. I concluded the analysis phase by validating the identified descriptors with the IENs as suggested by Colaizzi (1978). The validation process occurred once during the research process it concluded the analysis phase of the research process.

Justification of Research Approach

The primary reason I adopted this qualitative inquiry was because it allows participants to be studied in their natural settings. Polit and Beck (2008) characterize descriptive qualitative methodology as lived experiences from the participants' point of view. Second, the descriptive phenomenology method is fitting for both epistemological and methodological reasons. For example, I believe that individuals have a unique perception of their experiences and understandings of their world. Such unique realities can only be revealed through their individual stories. Lopez and Willis (2004) describe phenomenology as an approach which is suited to the values and beliefs of nursing – in that it seeks to “understand unique individuals and their meanings, interactions with others and their environment” (p. 726). IENs can be described as a unique group of nurses, in that they represent nurses from diverse educational backgrounds (Blythe & Baumann, 2009), cultural influences (Daniel et al., 2001; Winkelmann-Gleed & Seeley, 2005; Xu, 2007), and different socio-political practice contexts and health care systems (Bola et al., 2003; Buchan, 2006; Davitz et al., 1976). Descriptive phenomenology is well-suited for this kind of research inquiry due to a lack of clear conceptualization in the literature in terms of how to efficiently

integrate and support IENs within various practice settings. For example, only in the UK are transitional programs a government requirement for all IENs (Zizzo & Xu, 2009). In Canada, transitional programs, licensure requirements, and practice standards are overseen by different levels of government, professional associations, educational institutions, provincial regulatory bodies, and non-profit organizations, such as CARE. Considering such inter-provincial variances, along with the scarcity of a well-defined support structure (Polit & Beck, 2008) for IENs as they integrate into various practice settings, a descriptive phenomenological approach was very suitable. It allowed for an in-depth narrative account that generated new knowledge to inform the creation of effective support programs and policies, as well as fill in gaps in the existing body of nursing professional knowledge.

Study Setting

This thesis study was conducted in Ottawa, a major city in the province of Ontario, and the capital of Canada. Ottawa is the second largest city in the province of Ontario. The population of Ottawa, according to the 2011 census, is estimated at 883,391 (Statistics Canada, 2011), with the province of Ontario having a higher than average immigrant population (Statistics Canada, 2009). It is suggested that IENs are likely to be employed in urban centres like Ottawa (Blyth & Baumann, 2009). From these accounts, we can assume that Ottawa (being a large metropolitan city) probably will possess a good representation of IENs with whom to conduct this study. Additionally, the decision to include IENs in Ottawa was based on convenience of access and my preference to maintain a homogenous participant group as much as possible (e.g., with similar provincial licensing legislation). Interviews were conducted at a time and place convenient for the participants: seven were conducted in an office located at their places of work; two were conducted over the phone as

requested by the participant, and two were conducted in a quiet room at the University of Ottawa. Every effort was made to ensure the surroundings were quiet, comfortable, and private.

Participant Recruitment

Upon approval of the study by the University of Ottawa Research Ethics Board, study participants were recruited through my own personal and professional set of networks and email contacts. Being a first generation immigrant myself facilitated the process. Word of mouth through my nursing colleagues and nurse educators whom I know personally, and the distribution of an email message and recruitment poster describing my proposed study (Appendix A) were the key recruitment strategies. Through my nursing contacts, IENs were informed to contact me directly or give permission for me to contact them. Participants were provided with an information letter that described the study (Appendix B). In addition, participants were also recruited through the snowball effect according to their consent to be part of the study. Snowball sampling technique is described by Marshall and Rossman (2006) as “identified cases of interest from people who know people who know people who know what cases are information rich” (p. 71). Additionally, the recruitment poster used to advertise the study was placed at local community centres, retirement homes, and churches.

A list of over 14 IENs was generated through these methods, eleven of whom were final participants of the study. IENs who participated in this research met the following study eligibility criteria: a) have been practicing as an RN in Ottawa for a minimum of one year and a maximum of five years; b) had obtained their nursing education outside of Canada. In this study, IEN is defined as a nurse who is currently working as an RN in Ottawa, but who received their basic nursing training outside of Canada. Purposive sampling technique was

used to guide recruitment of study participants. This was illustrated in my decision to restrict the study participants to IENs who currently practiced as RNs only in Ontario to maintain a common scope of practice amongst all study participants. Sandelowski (2000) describes this strategy as one that allows the researcher to search for participants who are likely to have mutual and distinct experiences, but across a broad range of different participants.

Sample

Two nurses declined participation in the study after they were sent the information letter and consent form (Appendix C) via e-mail. Reasons given for not participating included having busy work and family schedules, and not willing to come in earlier or to stay at the end of a work day in order to complete the interview. These IENs who declined participating in the study were also not willing to have the interview completed at the University of Ottawa's quiet interview rooms. For instance, one IEN withdrew from the study after multiple attempts to re-schedule a suitable time to complete the interview by not returning my phone calls or e-mails. Throughout the data collection process, I questioned why some IENs were willing to discuss their integration experiences while others were not. To maintain uniformity in the RN license qualification and scope of practice, I focused on recruiting IENs who have successfully obtained licenses and were currently practicing RNs. Also, as part of establishing boundaries for the research, the issue of interest and purpose of the study was restricted to IENs integration experiences while integrating as RNs within the province of Ontario. Maximum variation through purposive sampling is evident in the diversity of IENs recruited. For example, IENs who are RNs of differing ethnicity, age, place of nursing education, and type and location of current nursing practice, with an ability to speak fluently in English about their experiences as nurses in Canada were recruited. Patton

(2002) encourages heterogeneity amongst study participants and this is congruent with purposive sampling techniques. A diverse sample enables the discovery of commonalities that are rooted in the different work experiences of IENs (Patton, 2002).

Data saturation occurred following the interviewing of eleven participants. This sample size has provided a comprehensive description of the phenomena of IEN integration into the Ontario health care system. According to Creswell (2007), a sample size of ten participants is adequate for a qualitative study such as this, highlighting the significance of having participants who have experienced the phenomenon of interest. Participants were recruited until the descriptions reached saturation, after which data collection stopped while data analysis advanced. Sandelowski (2008) describes data saturation to have occurred when the same information occurs repetitively; and can be anticipated by the researcher. Also new data collected adds no additional interpretative information to the research. Attaining data saturation enabled me to encapsulate an in-depth and comprehensive list of descriptors about IENs' experiences in Ontario.

Demographic Profile of Study Participants

Basic demographic information was collected from each participant using a demographic questionnaire (Appendix D). Study participants included nurses who were trained from countries in Africa, Eastern Europe, Asia, and South and North America. Figure 1 shows the countries of origin of the participants. The questionnaire data included questions about gender, age, marital status, country of origin, immigrant status, number of years living in Canada, number of years working in Canada as an RN, place of basic nursing education, year of graduation, highest level of education, current employment status in Canada, type of work specialty, and memberships in professional associations. All study participants were

female, all but one was married, and all had landed-immigrant status. They ranged in age from 25 to 47 years old with an average age of 34 years. This is similar to the average age of IENs in Ontario who are 33.5 years old (CNO, 2012). This value is higher than the overall average age of 28 years for Ontario nurses (CNO, 2012), suggesting the steady age increment of RNs in the province of Ontario. Additionally, over the next decade or two, IENs are likely to be represented amongst the higher age groups of nurses in Ontario if the age trends remain unchanged.

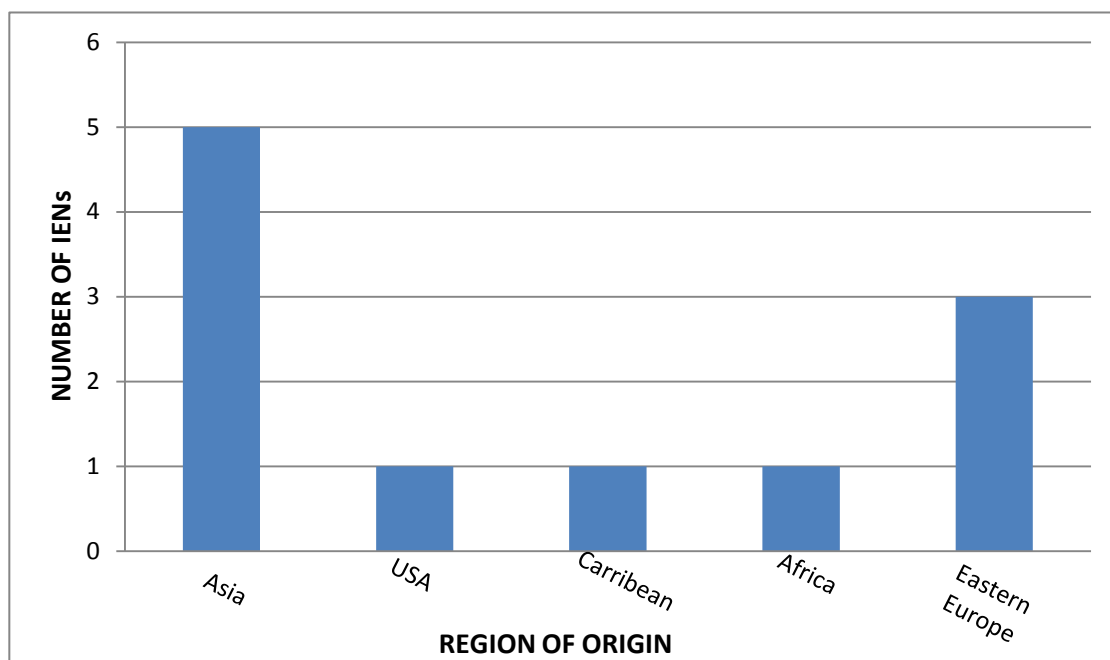


Figure 1: Region of Origin

Thirty-six percent (n=4) of IENs reported having a nursing diploma as their highest educational level, another 45.4% (n=5) had a nursing degree as their highest educational level, and 18% (n=2) had a master's degree as their highest level of education from their countries of origin respectively. One of the IENs with a diploma reported having submitted admission documents towards obtaining a nursing degree, meanwhile the other IENs reported an increase in family commitments resulting in a delay in advancing their education.

However, they had taken various specialty courses and certification such as OR or peripheral intravenous insertion certification courses in order to remain competent in the field.

Employment demographics of the participants showed a wide variety of experiences both outside and within Canada. Of the eleven IENs interviewed, 72.7% (n=8) were employed full time and two were part time (one by choice due to her present family commitment, and the other due to an unavailability of full time employment at her place of work). The other specified being casual, not by choice, even though she testified to working full time hours for her employer, a community nursing agency. Ninety point nine percent (90.9%, n=10) of IENs were employed in an acute care hospital setting; nine out of 10 of those who worked in hospitals were presently in specialty care settings, such as mental health, OR, or critical care. The remaining 9.1% (n=1) worked with a community agency due to her unsuccessful attempts to find employment at hospitals in the area. None of the IENs reported working in an administrative, educational, or research capacity despite their years of clinical nursing practice experience in their home countries.

Data Collection Strategies

Data collection for this study was accomplished through the following strategies: an in-depth participant interview as the main source of data collection; notes from a follow up discussion during data analysis and validation; and, a personal research journal. An in-depth semi-structured interview is consistent with phenomenological research traditions (Lopez & Willis, 2004). Patton (2002) describes it as a means of finding out “those things we cannot directly observe such as behaviours that took place at some previous point in time, or how people have organized the world and the meaning they attach to what goes on in the world” (pp. 340–341). Nine interviews were conducted face-to-face while two were conducted over

the phone according to the participant's preference. All interviews lasted for approximately one hour and comprised open-ended questions and active listening to the participants tell their stories. An interview guide (see Appendix E) was used which consisted of questions that explored the meaning of IENs' experience as they integrated into various work settings as RNs. Open-ended questions were used with each study participant to uncover her experience, such as, "Describe to me what your work experience has been like in Canada after obtaining your RN licensure." This strategy is consistent with the philosophical principles of descriptive phenomenology, in that it allowed me to understand the essences and universal meanings of their experiences. Prompts were used to obtain more detail and elaboration in participant responses. Interviews were audio-taped with the consent of the participants. In four cases, participants declined to give their consent to have the conversations audio-taped, expressing their uneasiness after I explained the interview process and confidentiality components. In these instances where audiotapes were not used, I listened attentively during the interviews and made notes of key points. However, immediately following such interviews, I wrote detailed field notes of the interview conversations. These notes were integrated into the coding and data analysis process. As a researcher and the instrument of data collection, my role was to guide the discussion, briefly take control of the discussion, listen actively, and re-direct the focus of the discussion to the phenomenon of interest as the need arose (Patton, 2002; Sofaer, 2002).

All tape-recorded interviews were transcribed verbatim. Both the taped-recorded interviews and field notes from the non-taped interviews were coded. I informed the participants that even though the interviews were audio-taped, occasional field notes were taken during the interview. Field note taking can serve as a means of communicating to the

respondent what aspects of their responses are of particular importance (Patton, 2002). The field notes enabled me to keep track of major themes and vital non-verbal cues. To facilitate this, I remained close to my data by concurrently performing data collection and analysis, listening to audiotapes, extensive reading and re-reading of the transcripts, as well as continuously reflecting on the data.

All participants were asked to complete a demographic questionnaire (Appendix D) at the beginning of each interview in order to facilitate the description of all participants. Field notes were taken to capture themes that became apparent as the interviews were done: non-verbal cues expressed by the participants, new ideas, thoughts, and questions that arose. More detailed field notes were taken for those interviews that were not audiotaped. In addition, I kept a personal journal to record details of my feelings and thoughts throughout the research process. Maintaining a journal record served as an audit trail that ensured the trustworthiness of the data. Upon completion of each interview, I critically reflected on the interview responses, extensively reviewed my transcripts, field notes, and journal entries in an attempt to expose “what was said,” “what I heard,” and “its meaning;” enabling me to keep track of major themes and vital non-verbal cues.

Data Analysis Procedure

Although the traditional data collection strategy for phenomenological inquiry is in-depth interviews and the product of the interviews are narrative reports of transcribed interview data, how these narratives are analyzed differs based on whether a descriptive or interpretative phenomenological approach is engaged (Lopez & Willis, 2004). Descriptive philosophical assumptions lay emphasis on describing universal essences (Wojnar & Swanson, 2007). Thematic analysis informed by a descriptive phenomenological lens was

used to uncover the essences of IEN work life experiences within the first five years of practice as RNs in Canada. A state of transcendence, which is described by Lopez and Willis (2004) as being neutral, was sustained through bracketing by continual journaling activities throughout the research process to bring into abeyance my preconceived opinions, knowledge, and biases about IENs and their experiences. Furthermore, rigorous bracketing enabled me to remain receptive to the data collected and their meanings. I analyzed the narratives of the IENs in accord with what they described as the meaning of their integration experience as RNs within the Canadian health care system.

Following the completion of all participant interviews and following the initial data analysis, a second contact was made with five IENs face-to-face and with three IENs by telephone. I was unable to make contact with two participants who were on vacation at the time, and one had recently relocated with her husband and family to another part of the country. This allowed me as the researcher to present the identified groups of themes and meanings to the participants throughout the analytical process in order to validate the findings. This follow-up discussion lasted approximately 30 minutes each and was not audio-taped. It enabled me to attain descriptive validity with the participants through member-checking (LeVasseur, 2003), and to further the analysis of the findings. Furthermore, during member checking, I followed Wojnar and Swanson's (2007) suggestion to "dissect the phenomena" by clarifying meanings of each significant word, statement, or category with participants. Additionally, other forms of communication, such as jokes, which are not readily accessed through a one-to-one interview, can be revealed (Kitzinger, 2006). An incorporation of identified themes and categories into comprehensive descriptors of IENs' integration within their practice settings took place. Validation of the identified descriptors

with the IENs towards the end of the data analysis concluded the analysis phase of the study (Colaizzi, 1978).

During the data analysis phase of this study, I recurrently read and listened to participant narratives, highlighted sections of transcripts, proposed ideas about the meaning of narrations, clarified and validated the proposed meanings, and organized meanings into groups of themes. All transcripts were printed double-spaced and formatted with a wide column on the right side to record the major themes and a column to the left to record its meaning as each transcript was reviewed. Quality audits were conducted by reading each transcript while simultaneously listening to the audiotape; any discrepancies were then corrected on the transcript. The audiotapes were reviewed three times for subtle expressions not readily captured in the written word and each transcript was reviewed several more times so I could become fully immersed in the data and observe emerging themes. With repetitive reviews of the transcripts, the identified themes became clearer and were categorized into four comprehensive descriptors, each with a few sub-themes of IENs' integration within their practice settings. These themes form the essences that are the basis of this study's findings and will be discussed in depth in the next chapter. Phrases or quotations from the participants are used to illustrate the meaning of their experiences within the various themes presented in Chapter Four.

Methods to Ensure Trustworthiness of Data

To establish credibility of these findings and overall rigor of the research process, the following steps proposed by Lincoln and Guba (1990) were undertaken. These authors proposed that qualitative research design should ensure that the quality of the data and findings are grounded in terms of their true value, consistency, neutrality, and applicability.

Lincoln and Guba use the concepts of credibility, transferability, dependability, and confirmability as the strategies for evaluating rigor in qualitative research. Each concept is described, with examples of measures taken in the study.

Credibility.

Marshall and Rossman (2006) propose that the initial goal to ensure credibility is to demonstrate that the study was designed in such a way that the participants were identified and described appropriately. This was done by observing the parameters of the study, including the inclusion and exclusion criteria and by identification of the limitations of the study. Maintaining the idea that prolonged engagement in the field and the synthesizing of data from multiple sources and methods enhance credibility (Creswell, 2007), I dedicated adequate time to immerse myself in the data through reading and re-reading each transcript. I used triangulation (i.e., multiple sources of data) to inform my analysis, which included my personal journal notes, interview transcripts, observation during interviews, as well as the existing literature on IENs to determine the consistency of my findings. I conducted follow-up phone interviews and group meetings with study participants which facilitated the member checking, by taking the general themes from my initial analysis back to the participants to validate my analysis, interpretation, and description of their stories, and to confirm these themes represented their account of meaning of their experiences. Participants generally confirmed that the themes I described during the follow-up discussions echoed their experiences. As well, Patton (2002) suggests performing a peer debriefing of research with other researchers in order to ensure the integrity of research skills and methodology. To this end, I had regular debriefing with my thesis supervisor who has expertise in conducting qualitative research and who reviewed my interview transcripts in detail. This provided the

opportunity for me to gain new insights, which improved my analytical skills as the research process evolved. To continue with bracketing techniques as prescribed in descriptive phenomenology research, I maintained a reflective journal which included my biases, values, and attitudes of my analysis as they evolved – a procedure recommended by Lincoln and Guba (1990) as necessary to keep the participants' narratives and interpretations relevant to mine. Keeping a personal journal of my thoughts, feelings, and reactions assisted me in documenting my personal growth as a researcher, as well as the evolution of the research process. For example, I documented my intuitions and decisions made throughout the research process.

Transferability.

Transferability is the second concept for evaluating trustworthiness and this refers to the applicability of study findings to other contexts (Lincoln & Guba, 1990). "The burden of demonstrating that a set of findings applies to another context rests more with the researcher who would make that transfer than with the original researcher" (Marshall & Rossman, 2006, pp. 201-2). As a researcher using a naturalist paradigm, I attempted to capture in detail the research process and actions taken as well as the rationale for actions in audit trails. This will make it possible for other researchers to follow the steps taken in my study thus facilitating transferability. Also, using rich, thick description, I illustrated in detail the participants or setting under study, allowing readers to make decisions regarding transferability (Creswell, 2007).

Furthermore, I enhanced transferability by ensuring maximum variation amongst study participants. For example, I recruited IENs from different educational backgrounds, working in different practice settings, as well as of various ages. By having a documented

account of my sampling strategy and data analysis, other researchers and users will be able to determine transferability to other contexts. Additionally, to facilitate triangulation, this study employed multiple informants, in-depth interviews, field notes, follow-up discussions (member-checks), and journaling as sources of data collection. I used field notes and a reflective journal to capture my thoughts and observations such as body language and non-verbal observations not captured on the transcripts. General observations I made, which were not captured on tape, were the facial expressions of sadness displayed as they recalled their integration experiences or happiness when they talked about positive contributions to the nursing team.

Dependability.

Dependability refers to consistency and appropriateness of the research process that will enable researchers to understand and attribute variations in realities to the source, a process described by Guba (1981) as, “trackable variance” (p. 81). Qualitative studies by nature cannot be replicated because the real world is constantly being constructed (Marshall & Rossman, 2006). As research themes emerged as the study progressed, I watched more closely for these themes in subsequent interviews. My reflective journal served as an audit trail that consisted of detailed documentation of the research processes, as well as decisions involved in analyzing and generating descriptions of IEN experiences. This record facilitated the judging of the quality of the research findings by an independent reviewer (Marshall & Rossman, 2006; Patton, 2002). To gain trust, I began my interaction with each participant by introducing myself as an RN and explained the purpose of my research and why I chose to study this phenomenon. I was watchful for visual cues of discomfort and acknowledged when they were observed, particularly in instances where IENs declined consent to be

involved in the study. All participants were informed that they did not have to answer a particular question if they found it uncomfortable and also that they could withdraw as a participant at any time.

Confirmability.

The final concept described by Lincoln and Guba (1990) is confirmability, which refers to the “neutrality” of the data whereby the interpretations and research findings are rooted in the data generated. This was done by asking an external source, a nurse colleague, to examine my inferences for logic (Marshall & Rossman, 2006). I utilized a colleague to play the role of a critical reader to thoroughly and thoughtfully question my analysis. Without any prior knowledge of the themes I saw emerging, my colleague reviewed anonymous transcripts; she presented the themes which made themselves clear to her. After her review, we discussed her findings, which matched the themes I was hearing. Also, I disseminated this study to my thesis committee members and my thesis supervisor giving them an opportunity to ask critical questions and provide constructive critique to my analysis, research methods, meanings, and descriptions generated (Creswell, 2007). Lincoln and Guba (1990) further suggest that neutrality is achieved when the credibility, transferability, and dependability of findings are met satisfactorily. I ensured that the mentioned steps were met throughout the study.

Ethical Considerations

Prior to commencing this study, a thesis proposal approved by my thesis committee, along with a completed Research Ethics Board (REB) application form, including all necessary signatures, copies of recruitment materials, and scripts, was submitted to the

University of Ottawa REB. Ethics approval was received (Appendix F). The signed consent forms are secured with my files in a locked cabinet.

Anonymity and confidentiality procedures were adhered to during all stages of the study. A pseudonym was randomly assigned to each participant and the data they provided so that their data are detached from their names to enhance anonymity. The list of pseudonyms is sealed in an envelope and stored in a locked cabinet in the office of my supervisor, Dr. Josephine Etowa, in the Nursing Best Practice Research Centre (NBPRC) at the University of Ottawa. A private record with the pseudonyms of each participant was kept in order to facilitate the researcher to connect data back to the participant for the purposes of contacting the participant for a follow-up interview (member-checking), and to clarify points with a participant after the data analysis began. Additionally, all audiotapes, interview transcripts, and field notes have been stored in this same secure location. Study data are only accessible to my thesis supervisor and me.

During the consent process, participants were informed that every attempt would be made to protect their anonymity during the writing of reports or published articles about this study. Participants were reminded not to discuss any part of this study with their peers and to be mindful of confidentiality agreements. Study participants are not identified in this thesis and they will not be identified in any publications that arise from this research. Permission to anonymously use direct quotations in the thesis report, publications, or oral presentations was sought during the consent process. All identifying information has been removed in the writing of the study results and pseudonyms have been used for all quotations made by participants. Interview tapes were offered to the participants upon completion of the study,

however all participants declined. All participants were informed of their rights to withdraw from the research at any time.

All study data will be maintained in the secure location as described, for five years following completion of the study, in accordance with the University of Ottawa policy. After five years, all of the study data will be destroyed through a secure shredding process.

Participants were informed that I asked a colleague to play the role of a critical reader of the data analysis and although fictitious names would be used for participants, certain circumstances describing an IEN's experience may be sufficiently distinct that it is possible to infer the identity of the participant. This colleague signed a confidentiality agreement prior to participating in this role (see Appendix G).

Another potential risk of participating in the study was the possibility of being emotionally upset as the nurse recounts experiences which she may have thought were behind her. To address this possibility, the interviews were conducted with great sensitivity, and in a location comfortable to the participants. A list of counseling resources was available should the participant become upset (see Appendix H), though this was not required by any participant at the time of the interview. Again, participants were reminded of their right to refuse to answer any question and their right to withdraw from the study at any time.

There are no known direct personal benefits from participating in this study. A potential indirect benefit from participating in this study was that it provided the opportunity for participants to tell their story and express their feelings that otherwise, they may never have had the opportunity to do. Another indirect benefit was that participants may have found it gratifying to know that the information they shared will inform nursing knowledge

and practice and may potentially benefit other IENs who may face a similar situation in the future.

In conclusion, this chapter has shown the research process beginning with data collection and ending with the writing of this research study, with each phase of the research process intertwined with the others in a non-linear manner. Data collection and analysis occurred concurrently leading to the generation of a number of themes presented in the next chapter, which focuses on the research findings.

Chapter Four – Findings

All IENs in this study reported feeling exhilarated upon obtaining their RN work license and employment, a process they described as a “long journey” with the CNO. This feeling changed as they encountered the reality of integrating into their workplaces. The essence of the lived integration experience of IENs who currently practice as RNs in Ontario is their resilience and their determination to belong and to provide quality nursing care despite daily challenges. The study findings are grouped into five major themes: a) relationship with colleagues; b) professional knowledge and experience; c) organizational practices and work environment; d) cross-cultural and linguistic competence; and, e) IENs as an asset to nursing and patient care (see Table 1).

Table 1

Research Findings Themes and Sub-themes.

1) Relationship with colleagues

- Teamwork
- Acceptance by patients and hospital staff
- Supportive work environment
- Incivility
- Proving self

2) Professional knowledge and experience

- Similarities between countries
- Differences between countries
- Clinical judgment

3) Organizational practices and work environment

- Support for professional growth
 - Professional learning
 - Insufficient support for professional growth
 - Inadequate time for orientation
- Unit and hospital practices

4) Cross-cultural and linguistic competence

- Language and communication barrier

5) IENs as an asset to nursing and patient care

Relationship with Colleagues

The IENs involved in this study worked in various specialties within acute care settings and all could recall vividly their experiences in terms of their relationship and interaction with their Canadian colleagues. Although the process of becoming an RN in Canada was exciting, the majority of IENs felt their Canadian colleagues questioned their knowledge and experience as RNs. This uncertainty created challenges in terms of their confidence during their transition period. Findings from this study suggest that nurses' attitudes within the work setting are likely to facilitate or hinder the integration experience of their colleagues. This theme refers to the issues associated with IENs' interaction and how they establish credibility with their peers in the workplace. Five sub-themes were identified under the theme of relationship with colleagues, including: a) teamwork; b) acceptance by patients and hospital staff; c) supportive work environment; d) incivility; and, e) proving self.

Teamwork. "...being an effective team member; and a professional worker"

The idea of utilizing a team approach to provide care was not new to the IENs involved in this study. In Canada, their respective experience with teamwork varied depending on the unit setting, that is, intensive care unit (ICU) or ward, and the group of nurses with whom they were scheduled to work. In this section, narratives from the IENs' stories will be used to illustrate the presence and absence of teamwork and the impact this had on IEN integration into the workplace. The IENs in this study described teamwork practices as vital for their successful integration experience, particularly during patient crisis situations. For example, as one participant said, teamwork is necessary to effectively manage clinical emergencies. This nurse described teamwork as the inclusion of all team members

when the need arises and she provided an example of a situation involving a patient crisis where teamwork was demonstrated. She notes:

In a patient crisis, team leaders will help; registered practical nurses (RPNs) will clear the room, orderlies, i.e., care aides will clean the room if necessary. There will be tasks delegated to all team members present. I use my judgment to involve other team members as necessary and you see improvement as a result.

The participant further noted that teamwork helps create positive interpersonal relationships and helps IENs develop a sense of belonging to the nursing team.

Two other IENs who worked as OR nurses at different acute care centres described their experience with teamwork in terms of patient outcomes as a positive influence on their integration. Good team practices are reflected when surgeries are completed in a timely fashion. For example, one IEN describes her experience as follows:

In Canada, there is no division between an experienced versus non-experienced nurse the way it's done in [Country of origin]. As a scrub nurse, you handle equipment, coordinate patient circulation to the OR and back to the ward, you make sure instruments are ready, when things go smoothly and on schedule, it is an achievement, it takes everyone's effort.

Another IEN described differences in interdisciplinary teamwork in psychiatric health care between Canada and her country of origin. Her narration illustrates a difference in IENs' training in their home countries.

With difficult patients here [Canada], you ask another team member for help, also the manager or psychiatrist; here it is different because in my country you work in nursing teams but you never ask a psychiatrist or manager for their input. It's not inter-disciplinary care there.

Yet another IEN thought teamwork values she learned in her home country made a positive contribution to quality nursing care here in Canada in terms of how she viewed patients at her work place, and how she attended to their needs, even to those not assigned to her daily work load. She states:

In [Country of origin] you get report[s] on every single patient, even those not assigned to you. You know something about all the patients; if you are done...you help others willingly. This defines the height of patient care. If someone [a nurse] is busy, it hinders the quality of care they [patients] receive; there is no "this is my load and that is yours" as it is here in Canada. Every patient is yours. If a patient needs something I take care of it, nursing care is ongoing.

Similarly, another participant compared her experience with the work environment here to where she was educated:

In Canada, there is no division between experienced nurses versus non-experienced nurses, there is no hierarchy, we all work together...and you have OR aides here, back homes the nurses do all the job, nurses have it easier here, but they still complain.

One participant describes teamwork practices common to nurses from her home country as they are taught in nursing schools there. She says, "In [Country of origin] you work in nursing teams; but you never ask for input from a physician or your unit manager...it is not interdisciplinary practice like here." She knew, understood, and has used the principles of teamwork within her discipline, a different teamwork approach from Western countries.

Another participant who is employed with a community agency relays the distinct experience of being frequently sent frequently to a specialized tertiary care institution. She is not part of the hospital team and she describes her experience with the absence of consistent teamwork practices. She portrays the uncertainty of her workday at this institution as follows:

I depend on others' personalities, some nurses become irritated if you ask questions while some are helpful. Sometimes others are not very helpful and this hinders question asking. This is a problem especially on this unit; patients are unpredictable due to their mental status.

The participant further describes the willingness or unwillingness of her work colleagues to engage in teamwork practices, and its effect on her experience. She states, "When we help each other with mental crisis, it's good. You can't work alone so you have to adapt" (referring to her colleagues' willingness to assist with patient care).

The nurse participants described their experiences with teamwork at their various workplaces. Their previous engagement in and understanding of team work facilitated their execution of team work behaviours with their nursing colleagues here in Canada. Nurses' perceptions of being contributing members of the patient care team seemed to set the stage for other experiences highlighted in their stories as being beneficial to their integration. IENs in this study regarded good teamwork practices as crucial to their integration experience; particularly in patient crisis situations as the perceived support of their work colleagues ensures that timely care is initiated and provided. To be part of the nursing team creates a sense of well-being.

Acceptance by patients and hospital staff members. "I didn't feel part of the team"

An important observation made after talking to all IENs in this study is that the feeling of being accepted or not by their nurse colleagues, patients, or family members either facilitated or hindered their integration experience. One participant described her experiences with patient and staff attitudes of acceptance as beneficial to her integration experience, saying, "I am a new nurse on the floor, you learn a lot from making mistakes, and the mentorship of more experienced nurses and their clinical judgment... my nursing colleagues are receptive, and I feel I am not left alone".

Other IENs explained their experience of being accepted by the compliments they get from patients, families, or their nursing colleagues. For example, one participant states, "At the end of the day some people (patients and families) are good at giving feedback...they send greeting cards to say thank you. This inspires you to work more".

One IEN explained that her encounters with nursing colleagues at her workplace contributed positively for the most part to her integration experience:

OR nursing is not direct patient care like on floors...you deal with colleagues, not patient care, some words are hard to pronounce, I have a hard time spelling some drugs, the nurses are good and friendly here, they help me.

Another IEN described the feeling of being accepted into her workplace as vital to the integration process and that an invitation from colleagues on her unit was a “welcoming” gesture, as follows:

In ICU we have a rich social life, we have book club, and nurses go out for lunches together, cafes or pubs at times...I get invited, but don't feel comfortable joining because of language, I have two kids and don't feel comfortable with the outing locations. I am happy I get invited. I hope to be more active with the book club.

One participant described how a welcoming and supportive compliment facilitated her integration stating, “When I get compliments from the nursing staff about my job performance...it makes me feel good about myself. It builds my confidence.”

Another IEN described the use of her clinical judgment which resulted in good patient outcomes at her workplace, stating, “The staff and nurse supervisor thanked me; my good clinical judgment facilitated their recognition of me as a knowledgeable and efficient patient care team member.”

Another participant explained that compliments from her supervisor contribute to an accepting work environment, “My supervisor gives me feedback on my performance, it's mostly good; other times it's not, but for the most part it's good.” Yet another described how positive feedback from patients and families enabled her integration into her place of work; she says, “Patients or their families make you feel good with their complimentary remarks, working with positive patients helps. Just leaving the room of a friendly and positive patient makes you feel good about your ability to provide care.”

In contrast, a different IEN attributed non-receptive attitudes by nurses trained in Canada to an ignorance of how to work with others, stating, “Make the environment

conducive...teach the nurses how to work with other people, because to come to work in another country is not easy; they need to put themselves in other people's shoes.”

Supportive work environment... “We get support from the supervisor”

One IEN described an instance of a supportive work environment in a critical care setting where she felt she was not too successful in managing a patient situation effectively. However, her perceived support from other staff members and the effects of teamwork at her place of work alleviated her feelings of anxiety and contributed positively to her integration experience. She stated, “Some patients are manipulative ...saying ‘the other nurse did not do it this way,’ you don't want to argue with them. If patients are very angry, we get support from the supervisor, social workers or other team members.”

Another participant further illustrates supportive work attitudes from her colleagues and ascribes this to the level of collegiality in the unit, saying:

In the ICU, I work well with other nurses on the same team, we know a lot about each other because it is a more intimate care setting in ICU, there's more consistent care, you get good report[s] and chart by systems [physiological systems] so you know your patient condition well. I spend a lot of time teaching families in ICU. I have supportive educators who don't sit in offices all day, but help on the unit...not only [by] sending you e-mails, they're very hands-on.

Yet another IEN describes the support she received from her work colleagues to care for a critically ill patient in an ICU setting, stating, “On a weekend, no educators available, you have support only from staff, I had a new admission...unstable, needing two nurses to help with care.”

Incivility... “I did not receive help from other nurses”

Not all IENs in this study encountered welcoming experiences from their colleagues or patients. All IENs could recall vividly non-welcoming encounters with some of their nursing colleagues or members from other professional teams, like physicians. At other

times, witnessing how some nurses acted with one another in a negative way left a negative impression in the minds of IENs. This negativity hindered the creation of professional and collegial work relationships with these nurses.

One IEN described her experience of working on a ward where she didn't feel accepted:

On the ward where I used to work, I didn't feel part of the team initially, being a new nurse, I worked part-time, received poor report[s] from the staff, and I have less time to spend with patients and families. I did not receive help from other nurses so I don't feel like offering help.

Equally, staff attitudes influenced how another IEN interacted with some nurses at her workplace. She explained, "I have a feel for people who are supportive to ask questions and I use them...I don't get involved in gossip or social groups, I keep myself neutral."

Similarly, another IEN described an incident in which some nurses acted in a non-professional manner with one another. Even though this incivility amongst nurses, and at times involving other professional teams were not unique to IENs', it shaped the IENs interaction with those involved and ultimately their integration into that nursing and patient care team. One IEN explains, "Some nurses don't like others, so you don't want to speak up, they talk badly about one another, if I speak up, then they will talk about me too...maybe I need to be more opinionated."

In addition, another IEN narrated her experience with a physician, describing it as discriminatory, "Sometimes they [referring to some surgeons] are mean to me...they will ask, 'Are you Canadian? I think the hospitals should hire Canadians first.' I need to learn to speak up more."

One participant described her challenges with workload and the work conditions on a unit due to a non-supportive leadership style. She reports:

We had problems with how the unit was run, it didn't matter if you were trained here or not...we felt as nurses we had no voice...our best wasn't good enough, we are too busy to do our jobs well, we all thought of leaving.

Another IEN detailed how certain physicians made her feel, stating, "Some surgeons or anesthetists if they don't like you, they treat you badly...they don't talk so this hinders communication."

One IEN gave an account of staff bullying resulting from staff differences and language barriers explaining, "I don't understand why nurses bully others [their colleagues] we need to be more patient and adjustable, I don't take the bullying personally; I am more tolerant...it's due to differences in situation, i.e., us coming to work here."

Proving self... "I had to prove myself"

The way nurses encountered and dealt with non-welcoming staff attitudes varied, but they all seemed to develop a resilient attitude to these unpleasant attitudes, one that forced them to focus and re-direct their efforts at performing better at their jobs. Detailed examples describing IENs having to prove their nursing knowledge are presented next. One IEN stated:

Everyone has their territorial thing. Before, they [Canadian educated nurses] thought I didn't know what to do because I came from another country. I had to prove myself when you shouldn't because the college has assessed everything. Now they're a lot more open than before once they see you know what you are doing they'll come around after you prove yourself.

Hindrances to workplace integration as a result of non-accepting staff attitudes were viewed by IENs as personal. Surprisingly, the unpleasant inter-personal experiences did not seem to relate to nursing knowledge or an ability to perform nursing duties, but rather to the IENs' perception of how accepted they felt by their nurse colleagues, which either promoted or hindered effective collegial relationships.

One participant described her experience as unpleasant; she was uncomfortable with the fact that nurses at her workplace were hard on her when she started working there:

You always have some staff who are difficult to work with and who gossip; especially about IENs; I just work hard to show them that I am capable...nurses are harder on IENs because they feel they don't have the same educational background as them. It's all the same; we wrote the same nursing exam so our training is the same.

Another participant expressed how she felt after experiencing a non-welcoming gesture from her colleagues. She at times felt the need to change who she was and to take up the "Canadian way" of expression:

Canadian trained nurses have some difficulty accepting us; sometimes people underestimate us, e.g., by their attitudes, maybe because of their mental status or it's just their personality...maybe I need to develop good communication skills...the Canadian attitude. We are less expressive culturally, most here are expecting more in terms of expression; just trying to change and adapt because we are working here now; knowingly or unknowingly we are learning to adapt...their attitudes change once they see your experience and knowledge.

Another IEN described how she had to prove her knowledge to her nurse colleagues and to physicians, stating, "I need to prove myself, that we're equal, that training is the same. The same with physicians and residents, you always have to prove yourself, but after a while it's okay."

In summary, these narratives portray how a collegial and friendly workplace can enhance IENs' integration experience and its meaning for them as RNs in Ontario. Good work experiences that promoted their integration consisted of more than just being able to get through their workday. IENs perception of a good and supportive work experience, one that fosters their integration, to consists of welcoming behaviours by their nurse colleagues, interdisciplinary staff, patients and families, and even the nurse supervisors. Attention needs to be brought to the negative attitudes and behaviours shown by Canadian-educated nurses and other professional members in the team in an effort to facilitate the creation and

sustainability of healthy work place environments for all nurses. Understanding the interaction of these factors is necessary for promoting effective IEN integration experiences.

Professional Knowledge and Experience

This theme refers to IENs' nursing knowledge and skills as well as previous experiences. Three main findings emerged along with two sub-themes namely, a) similarities between countries, b) differences between countries, and c) clinical judgment. Descriptive examples of the sub-themes are next.

Similarities between countries.

The similarity sub-theme describes aspects of the nursing program in Ontario that are similar to that of the IEN's country of origin, thereby facilitating their integration. Also, similarities between clinical specialties were IENs currently worked to those of their countries of origin ensured an easier transition into workplaces here in Ontario. For an IEN, her previous experiences with integrating into a different health care system in another country eased the process of integrating into Ontario's health care system. This sub-theme also describes the extent to which IENs were at ease with performing their respective roles as nurses in Canadian work contexts as a result of their prior nursing knowledge. For example, one IEN described the similarity between basic nursing training in Canada and training in her country of origin as a positive factor with respect to her integration experience. She recalled the similarity of the nursing textbooks and content of her training in Canada to that of her country of origin, stating:

The first basic part of education I had from the [country of origin] helped my integration here because it provided me with the skills I needed to know as a mental health nurse. We use the same textbooks and best practices. I also studied in English, which helped. We had the same basic foundational teaching and knowledge on how to nurse as here.

She further attributed her time management and organizational skills to her training in the [country of origin]:

My training back home taught me how to time manage and to prioritize, for instance I can co-ordinate multiple task[s] at the same time, managing changes in patient moods on a mood disorder unit, coordinate leave of absences (LOA) for weekends...patients leave quickly with no complaints of missing their medications, I check the physician orders ahead of time. I love my job and what I do; I have always wanted to be a mental health nurse.

Another IEN described a similar experience in which her nursing training content was similar to that in Canada, saying, "Nursing is different everywhere in terms of equipment, e.g., electric equipment, but the basics of nursing [are] the same... training on how to take a blood pressure is the same, it does not change".

Similarly, another participant attributed her experiences of familiarity to her past professional development and experience in the US, affirming:

I learnt to work the way I do from my educational training in the [Country of origin]... I brought most of knowledge with me in my five years of nursing in [Country of origin]... here there are some differences in documentation styles, e.g., paper charting...in my country of origin we use electronic charting...I built on other skills here; I haven't learnt nothing too new.

Other IENs had extensive experience and clinical expertise with the nursing work in certain clinical settings. Similarity between their previous areas of practice in their home countries and the Canadian context of practice, as well as the nursing skills involved in care, had a positive influence on their integration experience. For example, one participant noted:

In [country of origin], I had experience working in a neurology 'neuro' unit; here I am working with the same patient population, so it's easy. I learnt the basic neurology nursing training in my home country, even though technology is different here, the way of practicing is the same. For example, I have experience with "Glasgow coma" scale; I have previously used it, I can understand and tell when patient is having a good day or not.

Another IEN had similar experience with workplace familiarity, crediting her home training with her ability to work and integrate easily into her current place of work:

In country I had previous ICU experience as a neuro-trauma nurse. My way of thinking and major part of knowledge I brought with me, here I only polished. Here there are too many protocols and care maps to follow...you have more support and resources here. In my country you have to use your own critical judgment, not all patients fit in care map. You have to involve critical thinking and assessment of patient. My good assessment skills helped me guide patient care.

Still, another had a similar experience. Her account of being an OR nurse in her country of origin facilitated her ability to do her job here in Canada. She had this to say:

My prior knowledge of OR nursing, of surgical procedures and when to communicate with surgeons during a surgical procedure helped me here. For example, even though the names of instruments are different from how we refer to them in [country of origin], you know what they are used for and you know the surgical procedure. Sterile techniques don't change, it's all the same, I just have to learn the names of all the equipment.

Similarly, a different IEN who had worked in the OR affirms that her familiarity with OR nursing from her home country facilitated her integration into her workplace by positively contributing to her ability to work effectively with her colleagues and patients. She reports, "My prior experience helped me secure a clinical placement here at this hospital which eventually led to my hire upon completion".

Another IEN values her expertise and sound clinical judgment skills in assessing her patients, stating:

Canadian trained nurses have things easy with care maps and pre-printed protocols, so if patient does not fit care map they don't know what to do next. We do not have care maps in [country of origin], we think by ourselves.

IENs in this study described their work and life experiences as assets that contribute to better patient care in Canada. For example, one IEN stated, "My prior experience in my

role as an OR nurse is unique...I am good at calming anxious patients coming down for surgery. I am also easy going and get along well with people”.

One participant described being accustomed to integration processes in another country (other than Canada) and its health care system as a whole. Her previous experience with integration into a different health care system facilitated how she perceived her integration into the Canadian health care system. For example, she recounts her integration process from [country of origin] to Israel and now to Canada, and sums up her experience as “tolerable”. She says:

My professional and life experience has been helpful to me. This is the second immigration process for me in another country, I know what to expect professionally to obtain your license, and personally with colleagues who bully others... it has made me tolerable and patient.

Similarly, another IEN described her familiarity with the Canadian health care system and how this facilitated her integration experience after obtaining her RN licensure. She narrates her experience as follows:

I worked as a nanny and also as a care aid with a community agency so I already had some integration into the Canadian culture. I had a feel of how nursing worked in Canada... by the time I started working as an RN I have had some exposure to the health care system.

Differences between countries.

Having to adapt to differences in nursing in a new environment and in a different country was common to all IENs in this study. The extent of the nursing practice variation they encountered at their workplaces was influenced by their previous work-life experience and their exposure to certain technological capacities, cultural norms, and nursing standards in their home country.

Learning Canadian nursing practices and new approaches to patient care posed a hindrance to an effective integration for IENs as they started work within Ontario health care settings in that they needed time to grasp the newer approaches to patient care and adapt to their role as nurses within Canadian contexts. One participant described her experience with death and life in the Canadian context:

I relied on explanations from my colleagues for what is best for the patient in religious and multicultural aspect of nursing, I had never had any experience with native patients...there are social differences; there are differences in every country in their approach to death and life.

One IEN described her experience with learning new aspects of the Canadian health care system; she explained how such information is important to communicate to IENs upon hiring:

Institutions who hire IENs need to make emphasis on interdisciplinary and available community services...if I didn't go to the bridging program here in Canada I wouldn't have understood how Canadian system works, e.g., what's free and not free; health coverage, community services etc. particularly for psychiatric patients who need to go back into the community.

One participant narrated her experience with certain Canadian behaviours which she had to learn in order to meet her patient's expectations; she described an example of differences in cultural standards as follows: "I am surprised at how much Canadians drink ice water...my patients will ask me at times – how come you don't have basic knowledge of how we live here?"

Another participant disclosed her experience with new ways of providing nursing care in Canada, particularly with medication administration:

Policies and procedures are different in any country, e.g., documentation or administration of medication, blood, there are differences like technology, instruments like the automated dispensing system (ADS) for medications, I am coming from a specialty hospital in [country of origin] so I had to start [learning]

from basic bedside care. I learn the culture of patients in order to understand their feelings.

Similarly, another participant describes her experience with newer technology and portrays the importance of having enough time to become confident and comfortable with the use of certain equipment. She reported, "Initially it wasn't easy in terms of the equipment, nursing is the same everywhere but the equipment like the electric equipment is different".

When asked to give an example, she stated:

I used to work as a maternity nurse, and the ultrasound equipment is different with the one we use in our nursing schools back home. You have newer ones here and ones that work well. Every country has unique ethics, so I had to learn the standards here...in my country we had very good theoretical training, but the practice is different. Here is more client oriented; even though you are taught this in nursing school, you don't see it, but here it is very evident, you have to put it into practice, you treat people well here and it is documented.

One participant described how she had to adapt to the way nurses work here in Canada by stating, "Initially it was different in responsibility; here you are more independent; for example during physical assessment...in [country of origin] a nurse does not do physical assessments, only physicians. Here nurses do full physical assessment".

Another participant described how she adapted to the Canadian way of documenting by exception. She stated this about the differences in documentation styles, "Paperwork is different here, we use 'SOAP' format to document in my country, here nurses document by exception, use flow sheets and chart in boxes, it was new to me [country of origin]".

Similarly, one participant described how differences in nursing practices here in Canada acted as a hindrance to her integration. Comparing her experiences in [country of origin], she stated:

In [Country of origin], RNs do not do blood draw, laboratory technicians do, no matter what time of day it is, also we do more vital signs during a blood transfusion

than here in Canada. We do more documentation here in Canada; in [country of origin] all documentation is computerized.

These barriers point to a need for reasonable “integration time” to be allotted to IENs upon their hire at their places of work – time to learn, absorb, and adapt to the Canadian way of providing care and to develop necessary professional or educational pursuits. As one IEN described it, “Professional language, like certain abbreviations, takes time to absorb.” The time required to learn these differences, which included technological capacities, certain cultural practices, nursing practice behaviours involved in assessment or documentation, and specific professional abbreviations, hindered a smooth transition into their places of work.

Clinical Judgment: “Quality decision-making”

IENs in the study felt they had exposure to clinical scenarios at their workplaces here in Canada that required them to use high quality clinical judgment, which resulted in improved patient care experiences. This decision-making ability promoted acceptance from their nursing colleagues and led to an easier transition into the nursing care team at their places of work. Instances requiring such clinical decision-making seemed to occur “after hours,” such as on weekends or overnight, when clinical administrators and other professional team members involved in patient care were physically absent. IENs described the use of good clinical judgment as ranging from knowing when to seek assistance from your colleagues to assessing and identifying a change in patient status. One participant described a scenario that happened during a weekend as follows, “I felt I couldn’t handle patient due to their instability, sometimes I have high expectation on myself, but it’s okay to get help; doesn’t mean I am incapable; it’s not a personal failure”.

Another participant portrayed her experience with exercising good clinical judgment in what she described as a good workday. She explains, “A good day doesn’t happen very

often, but when you use your judgment to involve other teams in [a] patient crisis, you have a sense of accomplishment when things turn out okay". Similarly, another participant described a medical emergency situation she encountered in a mental health institution over a weekend and how she handled her patient despite the absence of medical directives to follow in such a case. She stated:

On this unit, all protocols are mental health related, my patient was diabetic, and I had to prepare him for a diagnostic test that required him to not eat prior to the test. I used my clinical judgment to inform the physician of his medical condition which prevented a hypoglycemic situation from getting worse.

Another participant demonstrated good clinical judgment and effective communication skills as a circulation nurse in the OR, as follows:

When assigned as a circulation nurse, you try to arrange everything so there is no loss of time. For instance, when you don't have enough instruments to work, you have to call around, you arrange surgical time to suit the surgeon and anesthesiologist, you call the ward to communicate surgical information to the nurses and get pertinent information about the patient.

One participant illustrated her good clinical judgment by her ability to self-assess and recognize areas of her nursing skills needing improvement and her ability to develop an improvement strategy. She explained:

If you know more, you are more comfortable, especially in vascular or neurology surgical procedures; these ones come in as emergencies [referring to trauma cases]. I need to do more surgeries in these areas so I ask charge nurse to put me in those OR areas.

Organizational Practice and Work Environments

The experience of working in a different environment (such as in Ontario) was a new phenomenon for most of the IENs and not one they seemed comfortable with initially. This experience generated a period of tension with other nursing colleagues, and at times within themselves, but for the majority of IENs it was a time of deep self-motivation to excel in

their nursing duties. In fact, I describe this period of integration as a time IENs “prove” their knowledge and skills as capable nurses to their colleagues. This theme describes the different hospital practices, work environment, and behaviours that influenced IEN integration at their workplaces in that it facilitated or hindered the acquisition of nursing knowledge needed to perform their job duties and to grow as nurses. These experiences will be described within two sub-themes, a) support for professional growth, and b) unit and hospital practices.

Support for professional growth.

In the sub-theme, support for professional growth, I will describe professional learning in terms of opportunities that foster IENs' professional learning and growth at their workplaces. Then, barriers to professional growth will be described within the sub-headings: insufficient support for professional growth, and inadequate time for orientation. The different organizational practices that influence IENs' integration experience at their various workplaces will be described in the sub-theme, unit and hospital practices.

Professional learning.

One participant described her experience with organizational support through technology during the integration period as valuable for her learning needs, providing easy access to learning resources at any time. She explained this about accessing policy and procedures, “Technology network like infonet [hospital internal network system] [provides] easy access to policies when I need it”. Similarly, another participant described her experience with accessing organizational policies related to her practice and how it facilitated her integration experience at her workplace, narrating, “Policies direct me in what I need to do; I have access to electronic copies online which is better than the binders...binders are not always updated.”

Another participant described the challenges associated with having a lot of information easily accessible:

There are lots of policy and procedure[s] on the computer whenever we need them...not very helpful because it's too much information and when I need it in an emergency situation, for example, I have no time to print it all and read it all especially if English is not your first language.

IENs in this study consistently found online learning as helpful to their integration into their places of work. For example, one participant described her experience this way, "I got directions whenever I needed to find something in the policy and procedure...I had learning information through e-mails, even mandatory e-learning courses for language training".

Aside from the relevant nursing practice information and resources readily available to all nurses, IENs included, to enable them to perform their everyday duties at their places of work, IENs in this study for the most part, described their experiences with professional learning as supported within workplaces in Ontario.

Insufficient support for professional growth.

IENs described support for professional growth as having paid time off from work to take courses to improve their nursing knowledge and efficiency. Depending on where IENs in this study worked and their learning interests, they all reported having attended educational opportunities even if those contributed little to their professional growth as nurses. Some expressed the need for more educational days in one fiscal year, for example:

We have two paid educational days a year...I attended a one day OR nursing conference sponsored by the OR nursing association, I requested additional educational days to attend more educational events but since I had used my two days, my request was denied...we need more educational days as nurses.

Another participant values the use of technology for professional learning but, as a nurse employed at a mental institution through a community agency, her experience was different. She explained:

The agency will not train or provide the policies for you, so I go the extra mile. To help myself, for example, I use the internet, YouTube to see how things are done here, sometimes I use my phone to access this.

Another participant described, "In OR nursing there is no procedure book, so effective communication is very important, a lot of hospital skill development courses [don't] apply to us OR nurses...we feel left out at times".

One participant described her experience with the availability of learning resources at her place of work as useful but superficial:

We have annual mandatory certifications like for lifts and transfers, hand hygiene, blood transfusions, how to use intravenous (IV) pumps...we have representatives come do an in-service for new equipments, [referring to the yearly mandatory certifications] ... most of it offers nothing to push your learning deeper, stuff you already know.

Another participant described her experience as, "I took more workshops as I become more comfortable in my work...I had educational leaves granted, this gave me a chance to take courses". Another participant also attended OR conferences as a result of being granted educational leave requests, describing these conferences as having provided necessary working knowledge, which helped with her integration experience at her place of work.

One participant, who does not get paid education days to attend conferences, described her experience working with a community agency:

I intend to go back to school [referring to the upcoming school year] because if you don't get the help you need, you look for help yourself. I have taken personal certifications like IV venipuncture at community college just to upgrade and integrate myself into the culture. I take courses, some I can't afford it, but maybe one or two day courses I take to know how it is in Canada...I make good use of online [YouTube] resources as well.

Even though a different participant had never asked for an education leave request, she expressed her plans to return to school to further her education, or move to another unit if her educational prospects were not supported by her current nurse supervisor.

In addition, one participant reported having attended educational days offered by the hospital she worked at this way, "I get one education day per year. I don't feel it's enough. I use internet to supplement my learning". Another participant also perceived having insufficient education days per year. She describes her experience as follows, "I have education days at my workplace but don't feel it's enough, I applied for the Registered Nurses Association of Ontario (RNAO) education initiative...a bursary. I have qualified for it twice".

Another participant described her experience with professional development opportunities to facilitate her integration: "Yes... I apply for educational days, I also attend the critical care nurses' day conference, I do think we need more time for professional development, or move to another unit, or settle with it". The general consensus on professional development and growth by IENs in this study seems to be that they had insufficient educational opportunities that enabled their professional growth. Some applied for and were granted available professional days. Despite the inconsistencies in the number of educational days granted per year, the majority expressed that having one to two days of paid education per year (as is the case for all RNs who work in Ontario) was not sufficient to support their professional growth, and ultimately this was perceived as a hindrance to their integration as nurses at their place of work.

Inadequate time for orientation.

IENs describe this sub-theme as the period from their date of hire to when they felt able to perform their nursing duties well. For a few IENs the process of integration into a new workplace seemed seamless as a result of familiarity with nursing knowledge and patient care practices. For example, IENs who came from specialties like the OR seem to have an easier integration due to similarities in the nursing duties involved. Meanwhile, others felt they needed more time due to features like technology, documentation styles, getting comfortable with the professional language, and different nursing approaches. Some IENs described their integration challenges as having resulted from how the health care organization runs. For instance, IENs felt their nurse supervisors were more concerned with their budget than investing in time to train them – a more corporate relationship once you were hired. Evidently, these IENs are at different stages in their professional and experiential achievement. A number of IENs thought hindrances to their integration were a result of an insufficient length of orientation received at the time of their hire. For example, one participant narrated an unsuccessful work experience due to a short and, in her opinion, incomplete hospital orientation:

I was new [in] a mental care hospital, working on evenings so less people to ask information...was alone in the nursing office and I had to send a patient to the emergency room and I didn't know which forms to use. From my mistakes, I learned to know where all the forms are on the unit. I did not know where some important forms are kept because of less training time I received, unit orientation was not enough; I learnt all that by myself.

She credits her insufficient knowledge of what to do on, “Not having enough orientation.” Such practices suggest either hiring organizations are not aware of the presence of IENs amongst their newly hired group of nurses at their organizations, who probably needs extended orientation time, or they do not acknowledge their need for extended

orientation period upon their hire. Another participant reported a need for longer orientation for IENs saying, "We have few buddy shifts...need more than that. So the beginning is hard. We need to be offered three months of orientation like other newly hired under graduate nurses". Likewise, a different participant who worked with a community agency staff RN stated, "Agencies do not provide enough training, so I go the extra mile to help myself by the use of Internet to improve my knowledge".

Likewise, another participant described her need for time to gain understanding of the professional language spoken amongst nurses, especially abbreviations used during her induction session into her place of work. She states:

They use acronyms here and you wonder what they are talking about, despite the need to write things out for someone new - it is a different language [referring to professional abbreviations]. If you don't know what it means during the induction session, with time you eventually figure it out. When you ask, you look like you don't know. They use abbreviations like ADL, CCAC, and ALC. They use it every day, even with orientation presentations, in fact throughout the presentation.

Similarly, another participant describes her need for time to become more comfortable executing leadership roles as an RN. She said:

In general people help me a lot, but on nights I have to be in charge-even though working for two years I still don't feel comfortable. Making staffing decisions...on nights I was working with a junior nurse, I was asked to "float"¹ one staff to a birthing unit operating room. Even though I am not allowed to send another staff except in a case of emergent surgery, I did not know this process...I felt bad, spoke with charge nurse in the morning and was told they could send a nurse only if all other resources are exhausted. I felt like I did not have the information I should have known from the beginning.

Due to unpreparedness for these situations, both mentally and emotionally, IENs felt less capable in performing their nursing duties. For example, IENs who were asked to "float"

¹ A situation where a nurse is sent to other floors or sections in the hospital to work as a result of a nursing staff shortage.

to another section or unit in the hospital stated that they were never informed of these practices; neither did they experience it during their orientation period.

The issue of the need for more orientation time was consistent among all participants in this study both to feel comfortable in their role as nurses within Canadian work contexts, and to support their professional growth. Another participant narrated this about the length of time allowed to her during her training as a newly hired nurse:

Had very few “buddy” shifts [shifts where a newly hired nurse is assigned with and works with a more experienced nurse on the unit]. Need more than that, so the beginning was hard. For example...offer consolidation of three months like other undergraduate nurses who are newly hired. I think IENs are able to work effectively in Canada after two or three years' experience.

Likewise, another participant described her need for time to become fully integrated the following way, “There are differences in the beginning like working in a different environment, communication especially in stressful situations and in emergencies, understanding physician's handwriting – we need longer orientations...hospitals who hire IENs need more money”.

Similarly, another participant described her need for time as something both IENs and the whole nursing and patient care team need to provide to facilitate integration. She explained how she developed a working strategy to maximize the time she had:

I got more integrated with time, I felt accepted after a couple of years. It takes time to feel fully integrated...coming from Europe the culture shock was easier...Canadian nurses have advantages with technology or with communication but with time it will come.

Yet another participant portrayed her experience with the business-like attitudes of some hiring organizations during her integration period into the health care system. Her narrative depicts a lack of support for IENs as they transition into the Canadian health care system. She stated:

Give IENs a chance. For instance I was turned down for employment at a certain hospital because I lacked Canadian experience...and at another institution because I didn't speak French language. They [referring to hiring institutions] should make time to train us, and for us [IENs] to adapt to the new environment. No one has time to mentor IENs, train the nurses [referring to IENs] to enable them adapt. I am good at looking and learning...allow time for IENs to adapt to the environment.

In summary, despite IENs needing more time to become accustomed to differences in nursing practices in Canada (such as e-learning technology, newer equipment, nursing and hospital practices like “floating” to other parts of a hospital), having access to learning opportunities that deepen IEN nursing knowledge promotes their ability and confidence to work effectively. This, in addition to better work conditions supported by superior union agreements and social services (such as the length of maternity leave entitlement in Canada), offers healthier work experiences for these IENs and makes their work life more pleasant.

Unit and hospital practices.

Unit and hospital practices describe the nursing or administrative routines that govern patient care. It also will portray how IENs perceive current work conditions at their places of work compared to their countries of origin. They testified that these work conditions facilitated their integration by making the experience more pleasing. I will describe in more detail how particular work characteristics eased their integration experiences. One participant describes her experience as follows, “Generally nursing is good here in terms of policy, for example good agreements with union in instances where you have to work overtime...union[s] are strong here”. In addition, one participant stated, “Here in Canada you have better equipment which makes it easier to do your job.” Likewise, another participant described her experience this way, “I like it here a lot, better benefits like maternity leave and sick time”.

Approaches to nursing care delivery seem inconsistent from one unit to another within the same organization. This is probably influenced by workload, staff-nurses-to-patient ratios, leadership, patient acuity, and other factors. For example, the way patient reports are delivered at shift changes seems to have an effect on IENs' comfort level at the start of the work day. One participant compares her work experience in an ICU and in a ward and explains:

At the start of the shift in ICU, report[ing] is very efficient, and it's done by systems, whereas on the ward it's not. It's easy to notice discrepancies in ICU. Every nurse gives report[s] their own way; there is no unified way of handing patients over to the next nurse. On the ward, I was nervous starting my shift...I felt like I didn't know the patients.

She further explained that on the wards you, "Spend time on tasks that RNs should not be doing like looking for equipment or other things...you are not available for your patients, whereas in ICU you have all the equipment you need". Further depicting certain hospital practices, another participant described particular work routines that hindered her integration on an emotional level. She expounded on her experience with "floating" to other areas of the hospital as stressful and as hindering her integration experience. She explains:

I don't like to 'float' to other floors...when I got hired I received orientation on my unit only. I am stressed when I have to 'float' to other units I know nothing about. The hospital needs to orientate not only IENs, but new hires to most hospital units especially those units that have issues with staffing or need nurses to 'float'.

Another participant gives further details on how "floating" can have a negative impact on the work experience. She described her experience with "floating" to another unit:

Buddy shifts just teach you how things are done on your floor...I was sent to work on another section of the hospital, as a result of difference on where equipment [is] kept on each floor, I couldn't find the equipment I needed to start a blood transfusion. I asked the team leader (TL) for help finding everything I needed. The next day, I was approached by the nurse educator ...holding a big binder she said to me—I was told by the TL you didn't know how to do a blood transfusion, I am here to teach you.

She described this experience as a hindrance to her integration, summarizing the encounter as an example of an assumption by Canadian nurses that, “Because you weren’t trained hereyou don’t know what you’re doing”.

Similarly, another participant sites workload as a hindrance to her ability to work effectively during her integration:

Here [in comparison to home country] nursing is more tasks oriented. No time to communicate with patients. When it’s very busy and you can’t find help, and patients get frustrated...with increased patient load, more sick patients, numerous family concerns, you have no time to stay with agitated patients or attend to family concerns. Families need to be aware of the increased nursing workload.

These IENs explain their inability to initiate good therapeutic relationships with their patients or with families as a result of their workload. The above descriptions illustrate broader organizational practices which hinder IEN integration. Even though these system practices, like floating to other areas of the hospital, are not experienced by IENs alone, IENs are probably disadvantaged. For instance, the IENs in this study required more time to adapt to the use of newer technology which they may have been exposed to for the first time; whereas their Canadian educated counterparts probably may have been exposed to this same technology throughout the course of their nursing education. Additionally, IENs reported needing more time to adapt to their new scope of practice and the different behavioral duties as RNs within Canadian contexts. This additional learning time influences their integration experiences in a negative way. They describe a good workday as one in which they are able to finish all their nursing tasks for that day.

Cross-Cultural and Linguistic Competence

Everyday work life as a nurse involves constant communication with patients, families, other nurses, and inter-professional team members involved in patient care. IENs in

this study who spoke English as a second language encountered barriers both in written communication (such as proper spelling) and expressive communication (like being fluent in speaking English or French) either with team members or to the patients. The others experienced challenges understanding patients' accents, particularly French speaking patients or their families. The sub-theme, language and communication barriers, will describe IENs' experience with cross-cultural and linguistic competence.

Language and communication barriers: "...taking phone orders is stressful"

When asked how language and communication were a hindrance to integration, one participant described her experience as more stressful when communicating with physicians in critical or emergency situations in that some physicians speak fast during telephone communication. She said, "Taking phone orders [is] stressful...I ask other nurses if it's [referring to written verbal orders] acceptable, it can be stressful". Another participant described her communication difficulty in terms of pronunciation. Even though her nurse colleagues were supportive and would assist her with proper spellings of medications or equipment, she gave details on how this made her feel, saying, "Nurses are helpful...when I ask for correct spelling, I get help".

One participant, an OR nurse, described her challenges with language by mentioning her fear of being misunderstood by the other party during telephone conversations. She described a telephone conversation in which she mediated between a floor nurse and the surgeon in the OR. Routine medication administration, common on the wards, is an uncommon practice in the OR. She was unfamiliar with floor nursing routines and medication dosages when she answered a telephone call from the floor nurse who had

questions about a medication dose that needed to be clarified by the surgeon who was already scrubbed and in the OR. She explained this experience this way:

I was anxious about being understood...I have difficulty with the medication doses...we don't give them here [in the OR], or getting verbal report for surgeon from the floor nurse. I never did floor nursing so do not know the order of ward routine. I am really weak at medication strength etc. because we do not use medications or do blood work in the OR. I was unable to communicate effectively between the two [surgeon and floor nurse]. Next time I ask to repeat order and amount of medications [medication strength]. It is difficult to interrupt surgeon during surgical procedure. Still learning Canadian medication system, not comfortable with phone call situations, I don't want to put patients in danger.

IENs who speak English as a second language feared being misunderstood when communicating with their work colleagues. Both understanding and communicating in the French language was a barrier to some IENs in the workplace. One participant recounts, "I do not understand the French language. Patients with French as their first language that has a French accent are difficult to understand". She further explains this about professional language which includes words like certain abbreviations or jargons, "About language, language has to be absorbed, professional language is different in that it is not taught in school; you have to work to attain a comfort level. Professionally, personally it has made me more tolerant and patient".

Another participant stated this about her experience with French or English language fluency, "Some IENs are less confident, they feel like they didn't practice language enough, I think they are just overwhelmed with all the information...not really nursing information, not being fluent in English or French triggers nervousness". Also another participant recounted that language in a crisis was an issue, saying, "If you want to ask something in a crisis, it's stressful with other co-workers especially with phone conversations with physicians; I still think of words to use".

IENs in this study felt their accents posed an issue of trust both to patients and to their nursing colleagues. One participant described her experience this way:

Patients don't feel trust right away because of accent...they're more suspicious; they ask about your training...they're afraid, but after doing your job well, they trust you. With my nursing colleagues, they didn't trust initially because of my accent. They verify with other nurses about my abilities and knowledge to provide care.

Similarly, another participant described her experience of ineffective communication with her patients. She says:

It was challenging in the beginning because of my accent...pronunciation of words, especially understanding and experience with French language was new to me...I didn't think about that [the French language] before coming to work in a hospital in Ottawa.

Another participant described challenges with language encountered with her colleagues within the first two years of her nursing practice in Canada. Originally from Eastern Europe, she cited her accent as a problem for her integration, stating, "It takes time to feel integrated, language barriers take time...people judge your accent to mean you're not smart enough".

IENs as an asset to nursing and patient care: "...multi-language competency"

IENs in this study represented nations from Asia, Eastern Europe, Africa, and North and South America. This sub-theme describes IENs' experience with caring for patients of different cultural backgrounds, and illustrates how diversity amongst nurses will likely allow the staff to relate positively to the diverse patient population of Canada, particularly those with whom they share the same cultural background. In fact, some acknowledged how their fluency in another language was a positive feature for the nursing team at their workplace. One participant's knowledge of other languages, like Cantonese, enabled her to contribute

constructively to patient care by communicating a certain family's needs to her nursing colleagues. She explains:

With a family from [country of origin], they will not ask for help even if they need it. This family expected the nurses to provide care to their loved one, but didn't since they [the nurses] saw family members always present and they provided care to their loved one [the patient]. Even though they were fatigued from exhaustion, they were afraid to ask for help. In patient's culture, they don't ask for help to care for their loved ones. After talking to the family in their native language, I communicated this cultural barrier with other nurses on the floor, and they became more aware of this cultural difference.

Another participant described how her knowledge of three Eastern European languages was helpful for patient care because she was able to communicate with patients and families who spoke these languages, which increased the understanding of their care and treatment plan and eased any anxiety the loved ones had about the hospital stay. She also credits her calm personality as beneficial to patient care. She narrates:

I have the knowledge of languages that are needed in patient care...I speak languages from countries [list of countries]. This contributed to quality patient care on the unit. Also I am able to figure out medication administration calculations easily because of stronger math background in home country. Canadian trained nurses' struggle with this. I also take my job very seriously and take responsibility of what I do...I love my job, I am quite calm and patient...I don't panic and this comes with years of experience.

Similarly, one participant illustrated how her interaction with a patient from [country of origin] which helped calm the worries and fears of both the patient and the family members and potentially prevented the loss of a workday for one family member:

We had a patient from [country of origin] coming for an operation. As soon as I greeted in our maternal language they were so happy and relaxed. Her [referring to patient's daughter] daughter left her work that day because she was going to translate during the procedure; she was happy I was able to speak our language and she was able to return to work that day. Also I really love my job; I am a workaholic, I love OR nursing.

Likewise, some IENs felt their life and work experience of practicing nursing in another country facilitated and enriched their understanding of certain cultural practices. One participant described her unique contribution to the nursing team in Canada:

I bring knowledge of international nursing after working in [country of origin] and in [country]. My knowledge about multicultural aspects enriches the patient care experience; I understand different cultures, different approaches to care and life span. Because of my twenty-five years of nursing, I am patient with differences. Nurses here [referring to Canadian educated colleagues] need to be more calm.

Another participant described her personal drive for success as valuable to nursing and to patient care in Canada:

My personal drive and prior experience is a good contribution to the patient care team. I study a lot to improve myself. I don't wait for things to happen...I make them happen so I can adapt better into the system.

One participant described her self-confident personality as contributing to nursing and to patient care as this enables her to remain focused and to grow in her job despite certain unwelcoming encounters at her workplace. She stated, "I am a very motivated person, I am intrinsically motivated and confident, I don't look for motivation around me. No matter what people say, I know what I know; I am going to do my best".

A participant who educated in [country of origin] described how she was able to support her patients in hospital differently, particularly those who wished to move to [country of origin] for medical treatment, by explaining different aspects of both health care systems:

I have seen both sides of private and public health care system, I have seen the benefits and weaknesses of both sides, and I bring an insider view of what some of the patients go through not paying for health care and those that pay for the service. The health care service itself is not different...there is no better treatment than the other. The treatments are the same, they don't change.

In conclusion, these nurses have provided valuable insights as to how their distinct contributions can influence the nursing profession and health care organizations in a positive

way. With effective support and integration, IENs can enhance meaningful and quality patient care experiences. These IENs mobilized both intrinsic and extrinsic resources to transcend the challenges associated with integrating into a different health care system and work environment. IENs in this study drew upon their own survival skills to cope with the stress they endured, which lasted up to two years from the time of their hire. These narrations provide meaningful understanding of different support gaps as well as strategies that organizations can offer IENs, or other internationally educated professionals, who are in the process of integrating into clinical practice work environments.

Chapter Five – Discussion and Implications

An analysis of the experiences of the IENs who participated in this study revealed a recurring theme of resilience. This internal resilience manifested over time in the IENs' unrelenting efforts to prove they were capable of providing care in a Canadian context. This chapter will provide an analysis of how resilience undergirded all of the other themes that emerged from the data. The themes will be organized into a framework that will guide the organization of the chapter. Current literature will be used to support the analysis and to highlight contributions of this study to existing literature on the integration of IENs into the workplace setting. The chapter will also discuss the implications and recommendations of this study for nursing practice, education, research, and administration. A brief discussion of the limitations of this study will be presented before concluding with key messages from the study.

Five intertwined themes evolved through the phenomenological analysis of descriptions in the IENs' stories of their lived experiences of integration into the health care system in Ontario. In addition to the underlying theme of resilience, the five themes included, a) relationship with colleagues; b) professional knowledge and experience; c) organizational practices and work environment; d) cross-cultural and linguistic competence; and, e) IENs as an asset to nursing and patient care.

Resilience and IEN Integration

The overall essence of the IEN experience is that of a personal resilience that led them to perform well at their nursing duties and to feel integrated into the nursing team. Ungar (2008) defines resilience as “both the capacity of individuals to navigate their way to health-sustaining resources including opportunities to experience feelings of well-being, and

a condition of the individual's family, community, and culture to provide these health resources and experiences in culturally meaningful ways" (p. 225). Ungar's definition, developed within the discipline of psychology and relating to children and adolescents, suggests an exchange between an individual and his/her surrounding context. Resilience has also been described as the ability to bounce back quickly from setbacks that occur during a lifetime (Zautra, Hall, & Murray, 2010). Common to both descriptions is the presence of an inner strength to overcome life's hindrances or obstacles. Earvolino-Ramirez (2007) identified attributes that characterize resilience, namely: rebounding/reintegration; high expectancy/self-determination; positive relationship/social support; flexibility; sense of humour; and self-esteem/self-efficacy. Instances where IENs exhibited the above attributes were evident in the stories they shared. Additionally, attention is placed on strategies that can be exercised within practice settings to foster resilience in an attempt to promote the integration experience.

Relationship with Colleagues

The common meaning of the narratives within this theme consisted of a sense of being part of the nursing and patient care team, and of being a knowledgeable worker within patient care contexts in Ontario. In this major theme, resilience was evidenced by IENs through their self-determination, creation of positive relationships, and flexibility. Tusaie & Dyer (2004) suggest that social support and significant relationships with at least one family member or peer are significant for resilient behaviours in adults. Supportive work relationships, characterized by effective communication (Tusaie & Dyer, 2004), are vital to promote resilience. These relationships can be exemplified within teamwork practices and the acceptance, by other nursing colleagues and team members. The idea of having support

during integration has been cited as vital in other studies in the field. Takeno (2010) affirmed that IENs found informal support from fellow nurses, community members, or support groups valuable for their integration experience. Kawi and Xu (2009) identified that IENs used their informal circles as a means of stress reduction. Similarly, Jose's (2011) study, using phenomenological traditions involving 20 IENs found that "support from co-workers [was] vital for adaptation to survival in the workplace" (p. 127).

In contrast, other scholars in the field presented IENs' lack of experience with teamwork as a barrier to their integration (Alexis & Vydelingum, 2004; Konno, 2006; Omeri & Atkins, 2002; Winkelmann-Gleed & Seeley, 2005). Konno's (2006) systematic review of 12 qualitative papers suggests IENs felt loneliness at the workplace, which resulted in the formation of informal support groups. Similarly, Alexis and Vydelingum (2004) suggest that IENs encountered minimal support in their daily work practices. The nurses in this study reported that knowing that their nurse colleagues were accessible to them when needed alleviated their anxiety, which ultimately facilitated their integration experience. Unpleasant experiences that result from non-welcoming attitudes towards IENs by their nursing colleagues or other inter-professional team members were also evident in the literature. For example, Alexis and Vydelingum's (2004) study revealed that Black and ethnic nurses in England encountered bullying and marginalization. Other examples of the different experiences of a non-welcoming attitude include: discrimination (Tregunno et al., 2009; Turriffin et al., 2002); lack of trust (Allan & Larsen, 2003; Bassendowski & Petrucka, 2010; Hearnden, 2007; Kawi & Xu, 2009); otherness (Omeri & Atkins, 2002; O'Neil, 2011); and isolation or racism (DiCicco-Bloom, 2004; Hearnden, 2007; Nichols & Campbell, 2010; Xu, 2007). In their interpretive qualitative study, Turriffin and colleagues (2002) shared that the

participants (who were immigrant nurses) reported feeling as the “other” during integration at their places of work.

Omeri and Atkins (2002) reported similar findings in a qualitative study using phenomenology traditions where the participants describe their experiences during integration as lonely and as feeling like the “other” due to their ethnicity, identity, and experience. Also, in 2004, DiCicco-Bloom’s qualitative research illustrates a differential treatment experienced by one participant who narrated the following, “The supervisor is a white man – he told one of the people I work with that he does not trust people who were educated outside this country” (p. 31). In DiCicco-Bloom’s study, IENs consistently felt that due to their accents, they lacked a working trust from their colleagues and patients. As a result, they had to prove themselves as capable and knowledgeable workers.

Likewise in this study, IENs reported a lack of trust from their nursing colleagues, patients, patients’ family members, and physicians. Others reported being bullied by their colleagues, a finding consistent with the literature wherein IENs reported feeling undermined and talked about by their nursing colleagues (Allan & Larsen, 2003; Tregunno et al., 2009). Omeri and Atkins (2002) shared that one IEN described and attributed her experience with non-welcoming attitudes from staff to a lack of understanding of other cultural norms. IENs in this study explained that when their Canadian-educated nurse counterparts critiqued their nursing knowledge, abilities, and experience, it felt as though their credentials and abilities were being evaluated for the second time.

Despite difficult experiences in different work settings, IENs were not deterred from performing their assigned duties as nurses. This attribute of self-determination (Ryan & Deci, 2000) highlights IENs’ resilient nature and a desire to have a stable work life with their

nursing colleagues. Earvolino-Ramirez (2007) describes rebounding as, “the process after disruption or adversity in which an individual wants to return to a regular routine” (p. 76). Their self-determination in the midst of adversity resulted in an earned trust from their nurse colleagues, and even patients at times, which ultimately led to an uncomplicated integration experience at their workplace.

Professional Knowledge and Experience

The theme of professional knowledge and experience refers to IENs' knowledge and skills, as well as their previous work experience, and how these contributed to patient care in Canada. In contrast to Blythe and Baumann's (2009) suggestion of that there are differences in nursing education preparation that impact professional knowledge and experience, IENs in this study reported areas of educational similarity, such as the use of the same nursing textbooks in the Philippines. They knew what to expect and were comfortable with their nursing duties. Familiarity with patient conditions and specialty units, work tools, and certain nursing textbooks identified in this study made their ability to provide care to certain patient populations seem seamless.

Content familiarity helped with the understanding and execution of protocols, and patient care procedures. This is consistent with the findings by Matiti and Taylor (2005) who indicated that because participant was familiar with a particular work setting, “he felt he could anticipate what surgeons needed, and also eye contact above the surgeon's theatre facemask indicated what the other staff members needed” (p. 10). Hart, Brannan, and DeChesnay, (2012), suggest that learned behaviours are the basis for nursing education and learning in the workplace.

Similar to Jose (2011) study's findings, the IENs in this study felt they needed time to acquaint themselves with newer technology than what they were used to in their home countries, Jose notes that , "While most IENs in this study group were pleased with the newer technologies used in the USA health care system, many told stories of needing more time, education and support to master those technologies" (p. 127). An understanding of the importance of IENs' prior work experience and its influence on their present experience is likely to promote integration into work environments where they can exercise their knowledge effectively to enhance patient care.

The use of computers to acquire relevant nursing knowledge and information was beneficial to IENs in this study. However, technology was also perceived a barrier, rather than a facilitating experience, for some. This finding is similar to that of Chenge and Garon (2010) who illustrate that IEN experiences with different technology and equipment at work was a barrier to their integration. Similarly, Blythe and colleagues (2006) reported IENs' struggle with newer equipment stating, "Others struggled with unfamiliar technology and worried that they appeared incompetent" (p. 207). IENs in this study equally reported needing time to become comfortable using unfamiliar equipment, like sonogram or other diagnostic equipment.

Organizational Practices and Work Environment

This theme describes the different hospital practices, work environments, and behaviours that influenced IEN integration either positively or negatively. Some hospital practices like shift change process was inconsistent and became an integration barrier for some IENs who felt that the process did not allow them to acquire enough information about their patients before commencing their shift. Such experiences dampen individual resilience

and hinder IENs' coping abilities in the workplace (Hart et al., 2012). Donald, Lazarus, and Lolwana (2010) argue that understanding resilience as a transactional phenomenon involving an individual and his or her surroundings is vital for creating comprehensive supportive work environments, ones that are likely to foster (or impede) integration. Given that successfully obtaining employment does not equate to a successful integration into the Canadian health care system, there is a need for continual access to the appropriate support and resources for the IENs after obtaining the RN license to ensure they are able to perform their nursing duties efficiently.

Despite the variation of learning opportunities encountered by IENs in this study such as attendance of nursing conferences, nursing certification courses, and the pursuit of a higher nursing degree, they unanimously felt such learning opportunities provided them with knowledge they needed to do their nursing work. This, in turn, supported their integration experience even when these were deemed superficial by some. Furthermore, in line with the insufficient support of professional learning and growth provided to IENs who work with community agencies, unless they voluntarily seek professional growth and learning opportunities, there is currently no means of identifying which IENs are in need of such professional support. Also, IENs who worked in OR settings reported feeling left out from hospital-organized learning in-services. IENs explain that hospital in-services, which refer to specially structured education sessions, consist of clinical procedures and skill acquisition in all specialties in nursing except OR nursing specialty. This inconsistency in meeting the educational needs of all nursing specialties within the organizations highlights the existence of systemic gaps in the integration of nurses in general. It is an issue with IENs in that being new comers to the province of Ontario, and in comparison to their Canadian nurse

counterparts, they are probably not all aware of the different learning resources, like professional bursaries, available to nurses to support their nursing knowledge acquisition. This demonstrates a need for more comprehensive education sessions, ones that are relevant to all nursing specialties, as IENs are likely to work within different nursing specialties in a hospital setting.

These descriptions point to current gaps in support for professional growth and advancement. IENs exemplified resilience in their self-determination to overcome these professional growth barriers by their intention to go back to school to further their career growth. Fowler (2011) points to the significance of trusted mentors to provide career guidance and role modeling in exploring career goals – a significant aspect within health care organizations that IENs in this study say was lacking. Some IENs felt the amount of educational leave granted by their respective organizations was insufficient, suggesting a desire to be increasingly proficient at their current nursing roles and duties.

A prominent concern among all IENs in this study was the issue of not having enough orientation time to feel fully capable at their places of work. This refers to the period following their hire, during which IENs accompany another nurse for the purpose of mentorship and to learn how nursing duties are performed within the organization. This finding was harmonious with other studies in the field (Bassendowski & Petrucka, 2010; Withers & Snowball, 2003; Xu, 2007). IENs felt hiring organizations did not offer comprehensive orientation sessions, including sessions that involved orientation time on other units of the hospital, particularly those that had issues with inadequate staffing and to which IENs sometimes had to float.

Situating the need for extended orientation time for IENs within studies in the field is notable. Extending their orientation time at their places of work is likely to enhance IENs' familiarity with their role as nurses within Canadian work contexts (Alexis & Vydelingum, 2004; Bassendowski & Petrucka, 2010; Blythe & Baumann, 2009; Jose, 2011); improve their know-how with equipment and technology used for patient care (Chege & Garon, 2010; Smith, Fisher, & Mercer, 2011); increase their ease with Canadian behavioural norms (Blythe & Baumann, 2009; Omeri & Atkins, 2002); and accustom them to patient care policies, regulations and the paper work involved (Matiti & Taylor, 2005). For example, Zizzo & Xu's (2009) systematic review shows that orientation programs are valuable for IENs, even though there are inconsistencies in the length of these programs and their content.

IENs in this study emphasized the need for more time to integrate well into their role as RNs in their work environment and into the Canadian health care system in general. In this study, the need for increased time to adapt to aspects of patient care, such as documentation styles, technology, policies, and procedures of both the hospital and especially the health care system in general was demonstrated. IENs unanimously demonstrated resilience as they persisted, and were willing to remain, at their places of work.

Earvolino-Ramirez (2007) suggests positive adaptation skills as an indication of resilience, facilitated by intrapersonal features like having an inner self-motivation (Hart et al., 2012). The authors state, "Nurses who are able to recognize and identify their own situational concerns, reframe, adapt and look forward to a time when the current situation might be altered were typically associated with higher levels of resilience" (Hart et al., 2012, p. 9).

Longer orientation periods, involving more than one hospital unit, and which includes human resource related issues like inter-hospital patient transfers and other staffing related procedures are vital to facilitate IEN integration. The different roles of professional teams in patient care, as well as the Canadian health care system as a whole, should be addressed. IENs reported having only a few buddy shifts after being hired, with their learning experience restricted to their units only. "Learning on the job" practices are likely to give rise to errors which can compromise patient safety and quality of care, increase frustration, and interfere with optimal integration experiences for the IENs involved. IENs in this study indicated an average time of two years as adequate for them to feel fully integrated as RNs in Canada. Understanding this vital component about IEN integration experiences is significant to promote collegial and supportive work environments and adds to a comprehensive understanding of IEN experiences with patient care in Canada. It also provides insight for bridging programs to create informative educational curricula for newer IENs in the country.

Cross-Cultural and Linguistic Competence

This theme presents both the challenges IENs faced at their places of work as well as how they felt they contributed uniquely to patient care in Canada. Resilience was evident in this theme in how IENs navigated language and communication challenges at their places of work. For example, IENs developed personal coping strategies to overcome different challenges pertaining to language and communication barriers. Some IENs reported taking French language courses to enhance the understanding of their French speaking patients, while others asked their nurse colleagues for proper word spellings. IENs were also able to identify which of their Canadian educated nurse colleagues were willing to address their questions and would use them. Identifying and developing effective coping and interpersonal

strategies facilitates resilience (Donald et al., 2010). Language and communication barriers encountered by IENs during integration at the workplace are not novel to either Canadian or international studies in the field (Bassendowski & Petrucka, 2010; Chege & Garon, 2010; Cummins, 2009; Deegan & Simkin, 2010; Kawi & Xu, 2009; Rogan, Miguel, Brown, & Kilstoff, 2006). For example, in their integrative review, Kawi and Xu (2009) stated that, "Differences in pronunciation, accent and terminologies limited international nurses' expression and understanding" (p. 176).

New to Canadian IEN literature is IENs' experience with the French language. IENs in this study encountered considerable difficulty in understanding patients who spoke French, as well as French speaking patients who spoke English with a heavy French accent. IENs attributed this challenge to the fact that they were located in the national capital region of Canada where there is a higher expectation for French proficiency, a fact they reported to have not taken into consideration prior to looking for employment. Other communication hindrances to their integration consist of having an accent, which as they describe it, made it difficult for both patients and their nursing colleagues to trust them. This issue of accent as an integration barrier is consistent with findings by Alexis & Vydellingum (2004) and Allan & Larsen (2003). Telephone conversations with physicians in patient crisis situations was also reported as a stressful experience for IENs in this study in that IENs were unsure of the other person's reaction or feelings about them. The fear of making errors while taking telephone orders and having the right spellings was a real concern for IENs in this study. This experience is similar to findings from other studies by Omeri and Atkins (2002), Magnúsdóttir (2005), and Xu (2007). IENs attributed this fear to their lack of a good command of English.

Furthermore, findings from this thesis study emphasizes the importance of inclusiveness behaviours like proper use of medical or disciplinary abbreviations during orientation presentation to all newly hired nurses, including IENs. The inappropriate use and clarification of disciplinary abbreviations is problematic since orientations are not only designed to initiate contact with respective hiring organizations, but also to offer a welcoming first impression and to portray an inclusive work experience within the health care organization. This points to strategies nurse administrators can employ to improve work environments for IENs (Baernholdt & Mark, 2009). Being aware of the unique needs some IENs may have is a starting point towards ensuring they are addressed within various workplaces. IENs need time to learn and assimilate abbreviations and to understand their use within the Canadian context of patient care. This helps minimize any undesirable emotional effects on their integration and promotes patient safety.

IENS as an Asset to Nursing and Patient Care

Studies in the field suggest IENs' integration experiences are problematic as a result of: their language and communication fluency (Bassendowski & Petrucka, 2010; Blythe & Baumann, 2009); accents (Chenge & Garon, 2010; Kawi & Xu, 2009); non-verbal communication cues (Cummins, 2009); and intercultural competence (Hearnden, 2007; O'Neil, 2011; Rogan et al., 2006). Given the increasing diversity of the Canadian population due to rising immigration trends, there is a need for Canadian studies that highlight the unique contribution IENs bring to the Canadian health care system and how their skills and knowledge add to culturally competent care. These were evident in the stories shared by the participants in the study. In one instance, the language proficiency of the nurse prevented loss of work time for a family member who otherwise would have stayed at the hospital to

translate. In another instance, explaining procedures and the plan of care to patients and families in their mother tongue, rather than in English, helped alleviate anxiety about their hospital stay. Distinct abilities like being fluent in multiple languages is likely to promote a sense of being valued both at their places of work and for patient care in general.

In addition, IENs consistently described their commitment and loyalty to their jobs as a positive contribution to the Canadian health care system. All IENs in this study reported having good job satisfaction in Canada. Their demonstrated commitment to their jobs is likely to sustain adequate health human resource needs in hospital care services. These intrapersonal characteristics highlight IENs' self-determination and adaptability – virtues which foster their resilient behaviours. IENs describe their self-motivation and a deep passion for their work as valuable work assets they contribute to the Canadian health care system and to the nursing profession.

Implications and Recommendations

The key deliverable of this thesis study is the creation of knowledge that informs future work in the field including program development and policies for IEN integration. The implications and recommendations of this study for nursing will be described for each of the nursing domains, namely, practice, education, research, and policy and administration.

Nursing practice.

A professional relationship grounded in trust amongst nurses is a professional standard learned in nursing education and expected by the CNO (CNO, 2002). As a standard of nursing practice, which results in good patient care outcomes, nurses are expected to demonstrate effective professional relationships and collaboration with one another. It is hoped the findings from this study will reinforce tolerance and respect amongst Canadian

RNs and other disciplinary team members, including physicians. Organizations are encouraged to conduct surveys to analyze the organization's current healthy work environment practices in order to expose gaps in effective professional relationships and collegiality. Findings from this study are likely to inform such surveys that might increase the potential of creating better IEN integration programs.

IENs indicated how they have applied the lessons learned during their integration experience into their current practice as RNs within Canadian health care contexts. One IEN encourages newly arrived IENs to seek out different programs, jobs, and learning opportunities that will expose them to the health care system and promote their exposure to the health care language and abbreviations. For example, she suggests that if newer IENs are able to secure jobs as personal care aides or nannies while waiting for their credential evaluation to be completed that might give them exposure to certain patient-caregiver language and abbreviations. This could also assist them in understanding patient-caregiver therapeutic relationships.

The creation of support groups for IENs at their places of work to ensure a supportive integration experience from the beginning, and to support the unique learning and clinical practice needs of IENs is necessary. This will provide a platform where IENs can ask relevant clinical practice questions and examine patient care scenarios without the fear of being embarrassed (Glass, 2009), determine if anything about their clinical practice can be done differently, and make recommendations for improvements (Gillespie, Chaboyer, & Wallis, 2009). In the absence of support in the workplace, some IENs relied on their family members for emotional support while others looked for peer-support from other IENs

Discussions surrounding patients or family scenarios and their influence on IEN integration experiences are likely to promote the anticipation and modeling of effective conflict resolution skills. In addition, developing individual strategies like critical reflection journals (Hodges et al., 2008) for problem solving and resolution are positive techniques to direct future patient encounters.

Nursing education.

Discussing diversity in working relationships in the nursing profession is vital to begin during undergraduate nursing education. Such educational training is essential in the context of the increasing diversity of the Canadian population and the health care team. Additionally, the educational training should be conducted according to professional practice standards and best practice guidelines pertaining to effective working relationships. Even though the inclusion and discussion of diversity in undergraduate programs may not eliminate the occurrence of unfavourable integration experiences, nurses entering the profession can be made aware of other cultural behavioural norms of patients and IENs. An increase in awareness is likely to facilitate conflict-resolution abilities relating to issues of diversity and diverse cultural behaviours.

Practice standards recommended by the CNO (2002) suggest the support of nurses towards the “development of skills to address any unethical, unprofessional or unsafe behavior of colleagues” (p.12). This speaks to the importance of good, respectful, and professional behaviour amongst nurses regardless of where they acquired their education. IENs in this study placed emphasis on the importance of being given time to adapt to their new Canadian work environment, the different ways of performing nursing duties, and the different cultural behaviours. Also, they expressed a need for Canadian-educated nurses to

understand the different cultural behaviours unique to other nurses, such as, being less expressive. Frequent hospital-run educational in-services and workshops that are designed to help IENs integrate and learn about the Canadian health care system and practices and also highlight diversity should incorporate educational initiatives as refreshers, and could include interactive diversity workshops or self-directed e-learning modules.

One IEN explained her experience with non-inclusiveness by describing educational gaps during the orientation presentations. Two IENs described the use of abbreviations referring to disciplinary teams or health services, which were unfamiliar to them as new nurses in the Canadian health care system. They discussed their inability, as new hires in a particular hospital, to voice their ignorance before a group consisting of Canadian-educated nurses, who are familiar with these abbreviations. This speaks to the importance of knowing the group of nurses you are inducting and their unique needs and also the necessity for best practice guidelines which can outline research-based ways to integrate IENs within the Canadian health care system. Additionally, the creation of informal and formal discussion forums for IENs is likely to provide a mechanism to voice their experiences and offer opportunities for positive change towards effectively integrating IENs within the system. Findings from this thesis study are likely to inform the creation of such forums.

Nursing research.

This study describes the integration experiences of IENs within the Canadian health care system after successfully obtaining their RN license. As previously shown, current evidence in the field tends to focus primarily on the licensure test numbers, pass rates and ethical dilemmas associated with hiring internationally educated nurses from less developed nations, as well as various eligibility challenges encountered by IENs. The findings from this

study will contribute to the Canadian perspective on the topic. No Canadian research studies were located which described the integration experiences of IENs as RNs, and the meaning this may have for them. Also no Canadian studies were located that explored IENs' distinct contributions to the health care system. This study has contributed to this area of research by describing IENs' lived integration experiences as RNs and the meaning of these experiences for them. It also contributed to an in-depth understanding of IEN experiences with patient care and their unique contribution to the nursing team in Canada.

Several IENs in this study described the need for supportive structures to be in place as a strategy to cope with the experience of integrating as nurses in Canada. The role of the family was not explored in depth in this study; however it would be interesting in future studies to explore the impact of the family as a support mechanism in coping with IEN work-life stresses. Other recommended areas for future research includes comparing the experiences of those IENs who went through the formal educational bridging program for IENs in Ontario with those with those who did not. IENs described their feelings of being evaluated for the second time by their nursing colleagues. The issue of post-licensure clinical competence equality between IENs and their Canadian-educated counterparts warrants further research. One IEN described her decision to work in the Nation's Capital as disappointing due to the requirement for French language proficiency, stating, "It's something you don't think about." Several other IENs describe their challenges with learning, speaking, and understanding French speaking patients, even when they spoke English. The effect of French language on IEN integration experience merits further research, particularly with those whose first language is neither English nor French.

Nursing administration.

A key message from this study that can be applied to nursing administrators is that IENs would like to be acknowledged and valued as knowledgeable and contributing members to the nursing team and patient care. Recognizing the need to create supportive work environments in which mutual trust and respect amongst all workers and disciplines is encouraged, and that nurtures the development of effective coping and resilience, is a responsibility to be taken seriously by nurse administrators. Supportive work environments can be promoted by acknowledging that IENs are going through a period of change (Fowler, 2011), one which is stressful and further compounded by their integration into a new work environment with different ways of performing their nursing duties. Having a designated person within the organization as a role model who is likely to understand their unique needs during this period can be relevant for IENs' integration (Fowler, 2011). All IENs acknowledged that knowing they are welcomed, trusted, and can seek assistance at any time was valuable to their integration experience. Findings from this study can inform organizations of such supportive roles and integration programs.

Nurse administrators can also ensure that appropriate structures are in place to effectively manage conflicts between IENs and their Canadian-educated counterparts. An example of such structures can be committees responsible for creating guidelines on effectively integrating nurses from different cultural backgrounds. IENs placed a significant emphasis on the need for more time to feel fully integrated into the workplace due to factors like differences in technology, work responsibilities, documentation, and time to build a working trust between them and their nurse colleagues, other discipline members, and patients. An established support committee within various work units that is in contact with

unit managers and that offers IENs resources of support within the community, such as language programs, bursaries from nursing associations, and – for those going through difficult integration experiences – free lunches, and a forum for confidential discussions, would provide an avenue for helpful advice from other IEN colleagues or nurses from similar backgrounds. Such support groups can act as a liaison with other IEN support associations, such as Creating Access to Regulated Employment (CARE), within community colleges, and hiring organizations. Also, offering nursing care and professional growth support through an Employee Assistance Programs (EAP) may be beneficial. While this study focused on nursing, the above recommendation would benefit all health care professionals. It would be beneficial to conduct interventional research in the future to evaluate the impact of such committees.

Nurse administrators can equally value and acknowledge IENs' expertise and contribution to the care of patients by creating incentive recognition programs whereby unique patient care interventions provided by IENs, such as language interpretations preventing family loss of work time, can be appreciated. This may serve as a service resource that could be utilized in other areas of the hospital. Another strategy for valuing IEN expertise is to facilitate their integration on specialty units in which they have prior experience. This would demonstrate efficient integration practices and the IENs involved would probably need less time to feel fully integrated into the workplace. Also developing a workplace culture geared towards valuing each other's contribution in a sustainable manner is likely when all nursing staff feel the support of their respective administrators. All these strategies aim to promote better integration experiences for IENs within the Canadian health

care system, encourage work commitment, and reduce potential emotional and financial costs involved with training IENs at various places of work.

Limitations of Study

A possible limitation of the study is the time constraints in conducting a Master's thesis involving the recruitment of participants with diverse and unique experiences, who are able to add to a comprehensive description of IEN experiences. The possibility of omitting IENs that have rich information data from the study is worth noting due to time constraints. IENs who declined the invitation to be part of this current study are likely to have rich data that could influence the depths of this study finding. Furthermore, the majority of IENs in this study worked in hospital settings, and therefore the results may not be transferable to all health service locations that hire IENs, such as nursing homes or community centres.

Conclusion

Effective integration of IENs as RNs into the Canadian health care system is a key step to developing a diverse and healthy workforce and is beneficial for the IENs, their Canadian-educated nurse counterparts, and for patients who may receive higher quality care as a result of a diverse nursing workforce. To foster successful integration of IENs and the subsequent creation of a healthy work environment, all stakeholders (i.e., IENs, Canadian-educated nurses, nurse administrators and policy makers, nurse educators and provincial legislation bodies) need to play a significant part, including gaining a comprehensive understanding of IENs' experience and acknowledging their distinct contribution to the nursing profession.

This research has explored the lived experiences of IENs as RNs within the Canadian health care system and the meaning of these experiences for them. While previous work in

this field predominantly discusses the challenges IENs face upon their arrival in Canada, such as credential evaluation, their license pass rates, and the challenges they face during their practice as nurses – either as RNs or as RPNs, this study has shown IENs' unique contribution to the Canadian health care system in terms of the promotion of diversity and cultural acceptance within health care service delivery. It highlights the need for more Canadian studies that examine the integration experiences of IENs after successfully obtaining their RN licenses. In addition, more studies are needed that explore existing gaps in integrating IENs within the nursing profession and the Canadian health care system as a whole, in ways that promote the use of their knowledge and expertise.

This descriptive phenomenology study has explained the essences of IENs' integration experiences. It is my belief that the findings of this study have contributed to new knowledge that would address existing gaps in the literature about the integration experiences of IENs into the Canadian health care system. It is also my expectation that these findings will positively influence future nursing practice, education, research, and administration.

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Appendix A – RECRUITMENT POSTER



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Exploring the Meaning of IENs' Experience as RNs within the Canadian Health Care System

Are you an internationally educated nurse, 30 years old or more?

Do you have a valid CNO license permitting you to practice as a Registered Nurse (RN) in Ontario?

Have you been practicing for a minimum of one year and a maximum of five years?

If you had your nursing training/education outside of Canada, and would like to share your experiences, I am very interested in hearing about your nursing practice experience in Ontario.

I am a Registered Nurse and a master's student at the University of Ottawa.

Please call me:

Ndolo Njie-Mokonya, RN, Master student

Thank you for your interest to participate!

Thesis Supervisor

Dr. Josephine Etowa



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Appendix B – INTERVIEW INFORMATION LETTER

Project Title: Exploring the Meaning of Internationally Educated Nurses' (IENs') Experience as RNs within the Canadian Health Care System

Principal Investigator/Masters Student: Ndolo Njie-Mokonya, RN, BScN, School of Nursing, University of Ottawa

Thesis Supervisor: Josephine Etowa, RN, PhD, Associate Professor, School of Nursing, University of Ottawa

You are cordially invited to take part in a study which will contribute to the partial fulfillment of the requirements for a Masters of Nursing degree.

What is this Study About?

The purpose of this thesis research is to examine the nursing practices of IENs after successfully obtaining licensure to become RNs in Ontario. Understanding of the experiences of IENs at the practice level within Canadian work settings will facilitate the creation of support programs to enhance effective integration, promote skill acquisition, and foster a healthy work environment for all nurses, irrespective of their background.

If you agree to take part in this study, you will be asked to participate in a 45 to 60 minutes interview. You will also be asked to complete a demographic form and to take part in a follow-up focus group meeting that will last for 60 to 90 minutes.

What would I have to do?

I have been invited to participate in this study because:

- I am an Internationally Educated Nurse (IEN)



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- I speak English
- I am 30 years old or more
- I have a valid nursing practice license issued by the College

of Nurses of Ontario (CNO) permitting me to work as a Registered Nurse in Ontario

- I have immigrated to Canada and I have been working as a nurse for a minimum of one year and a maximum of five years.

Each participant will be involved in one or two face-to-face interview(s). The interview will be mainly about your nursing practice experience in Canada. Other questions may be asked to explore issues that are important to you. With your permission, the interview will be taped recorded. Each interview will last approximately 45 minutes to an hour. I will share the research findings with participants at the end of the study in a group meeting that will last approximately 60 to 90 minutes.

Your Rights and Related Information for Participating in this Study.

Risks and Benefits

Talking to me about your nursing experiences as an IEN in Ottawa may bring back some pleasant or unpleasant experiences about your integration in the health care system. You will be asked to reflect on these experiences, and in the process may experience some discomfort. If you were to recall some unpleasant experiences you can refuse to answer any questions and I can turn off the tape recorder at any time during the interview. A telephone number of a counseling service will be given to you in case you require further support. There is no obligation to participate in this study. You may also choose to withdraw at any time. If you choose to withdraw from this study all physical copies containing personal and research data

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collected will be returned to you immediately. Also, personal and research information in computer files will be securely deleted. In addition you can call research Protocol Officer for the University of Ottawa at any time to talk about the interview.

Are there benefits to taking part in the study?

There are no assured benefits to taking part in this study. Some possible benefits may include being able to reflect on, and discuss your personal experiences. Your personal experiences may potentially benefit other IENs in similar situations, influence policy and contribute to an in-depth understanding of the experiences of IENs as they integrate as nurses in Canada. Additionally, the data collected from this study may contribute to the development of better support and integration programs and policies that can promote healthy work experiences for all nurses. **Do I have to participate?**

Your participation in this study is voluntary and you may at any time choose to withdraw from the study without any negative consequences to you.

Compensation/Reimbursement

There will be no compensation for taking part in this study; however, bus tickets and parking costs will be compensated if you decide to travel to the University's private interview room for an interview.

Confidentiality/Anonymity.

Your name or personal information will not be used or shared in the study. Fictitious names (pseudonyms) will be assigned to all participants, and will be used when publishing the research findings. The list of pseudonyms will be kept in an envelope and stored in a locked cabinet at the Nursing Best Practice Research Unit (NBPRU)

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at the University of Ottawa. Furthermore, all papers, interview transcripts, audiotapes will be locked up in this same secure location for a period of five years and then destroyed. Study data will be accessible to the researcher and thesis director only. Although efforts will be made to ensure confidentiality, the researcher cannot guarantee that other participants will do the same so everyone will be advised to keep what is shared within the group confidential.

Ongoing Information

You can ask questions about the study at any time. The researcher will provide you with complete information about the progress of the study in a timely fashion. If you have any questions or concerns about the study please contact:

Ndolo Njie-Mokonya
451 Smyth Rd (Room 3051)
Ottawa, On
K1H 8M5

You may also contact the University's research Protocol Officer:

Protocol Officer for Ethics in Research
University of Ottawa, Tabaret Hall
550 Cumberland Street, Room 154
Ottawa ON
K1N 6N5



Appendix C – INTERVIEW CONSENT FORM

Title: Exploring the Integration Experiences of Internationally Educated Nurse (IEN) within the Canadian Health Care System.

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I acknowledge that I have read and understood the explanation about this study as indicated in the attached “Letter of Information”, particularly as it concerns the nature of my participation in the research project. I have been given the opportunity to discuss the study with the researcher. Any questions pertaining to my participating in the study have been addressed to my satisfaction. I understand that my participation in this study is voluntary and I have the right to withdraw from this study at any time without penalty. Physical copies containing personal and research data collected will be returned to me immediately if I choose to withdraw from the study. Also, personal and research information in computer files will be securely deleted. I freely and voluntarily consent to take part in this study. I will be given a signed copy of this form.

Signature of Participant

Date

Signature of Investigator

Date

I authorize the investigator to audiotape any interviews I participate in throughout the study. I understand that I may request to have the tape recorder turned off at any time in any case where I do not wish to be recorded.

Signature of Participant

Date

Signature of Investigator

Date



I understand and authorize for my words and/or statements spoken during the interviews to be quoted anonymously in the final report, publications or final dissertation of the study findings.

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Signature of Participant

Date

Signature of Investigator

Date

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A copy of the signed consent will be given to each participant. Original signed copies will be kept in a sealed envelope, separate from other study data, and locked up in a cabinet at the Nursing Best Practice Research Unit (NBPRU) at the University of Ottawa.

If you have any questions about the ethical conduct of this study,
please contact:

Protocol Officer for Ethics in Research

University of Ottawa, Tabaret Hall Room

550 Cumberland Street, Room 154

Ottawa ON K1N 6N5

Email: ethics@uottawa.ca


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Appendix D – DEMOGRAPHIC QUESTIONNAIRE

These questions are intended to provide some background information about you. It will enable me to describe in general terms the people I interviewed. All information will be kept strictly confidential.

Name

Preferred method of contact:

Phone

Email:

Address/contact information: _____

(For mailing completed thesis only if requested)

Sex: Female Male

Age:

Marital status (circle): Single

Married

Country of Origin

Immigrant Status: Landed-Immigrant Citizen Refugee
Other

Number of years living in Canada:

Education: Degree/Diploma Year of Graduation Place

Place of Basic RN Education:

Member of a Professional Association?



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Do you currently work: Full time Part-time Casual

Type of employment: _____

Total number of years in nursing: _____

Current specialty of work in nursing: _____

Med/surg Obstetrics ICU Emergency Other (specify):

Years of experience working: in Canada outside Canada as a nurse

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Appendix E – INTERVIEW GUIDE

1. Please tell me about your work experiences as an IEN who is currently practicing as a Registered Nurse in the Ontario health care system.

- Can you briefly outline what you do on an everyday basis?
- Who are the people you work with most closely?

[Probe for them to talk about patients/clients or colleagues]

- What is the nature of your work with [other] Registered Nurses and nurse supervisors?

I am going to use the term “nurses” to cover RNs and LPNs generally, but please let me know when you are making a distinction between the two!

2. When do you feel you have been most successful in working with patients? With your colleagues?

- What was it that supported your work – so that it was successful?
- What supported it in terms of your past personal development?
- IF not supported here – What do you think could help you in your own personal development to support your work? What would have to happen?
- What supported it in terms of professional development opportunities?
- IF not supported here – How do you think your professional training could support your work? What would have to happen?
- What supported it in terms of institutional resources – such as policies and procedures?
- IF not supported here – How do you think the institution could have supported your work? What would have to happen?
- What else supported you in your ability to work effectively with patients and colleagues?
- Where did you learn how to work in this way?

3. When you think about your work in your institution, what are some contributions you feel you bring to improve patient care?

- What happened? What did you do? In that instance, how did it improve patient care?

4. When you look at the work of other nurses in your institution, what have you seen that you feel demonstrates working effectively with patients and colleagues?

- What do you think supported that work?

Personal development, professional training, institutional resources, policies and procedures.

....

- What did you learn from that situation?

5. Can you give me an example of a situation where you feel you were NOT successful to work effectively with a patient or colleague?

- What do you think got in the way of that work being effective?

Personal development, professional training, institutional resources, policies and procedures.

....

- What did you learn from that situation?

- What do you think needs to happen for situations like that to have a better outcome?

6. Can you give me another example? [Use the same prompts.]

7. When you think about your work and your workplace overall, how hopeful are you that it is possible for IENs to work effectively with patients and colleagues?

- What is it about your workplace that offers you hope?
 - What is it about your workplace that makes you feel less hopeful?
- What is it about your colleagues and the profession of nursing that offers you hope?
 - What is it about your colleagues and profession of nursing that makes you feel less hopeful?
- What is it about yourself that offers you hope?
 - What is it about yourself that makes you feel less hopeful?
- What else offers you hope?
 - What else makes you feel less hopeful?

8. In order for IENS to work effectively with patients and colleagues within the Ontario health care system, what do you feel are the key changes that have to happen at an institutional level?

- What is needed for that to happen?

9. What are the key changes that have to happen at a professional level – for IENs? For all nurses?
 - What is needed for that to happen?
10. In order for IENs to work effectively with patients and colleagues, what changes do you feel you have to make, personally?
 - What is needed for that to happen?
11. What do you think will MOST get in the way of institutions, the profession and individual people making change?
 - What will get in the way of the institution changing?
 - How can we get over this barrier?

 - What will get in the way of the profession changing?
 - How can we get over this barrier?

 - What will get in the way of individual people changing?
 - How can we get over this barrier?
12. Is there anything else you would like to say about the issue of IENs working effectively with patients and colleagues in Canada?

THANK YOU!

Appendix F – ETHICS APPROVAL NOTICE**Université d'Ottawa**

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

Ethics Approval Notice**Health Sciences and Science REB****Principal Investigator / Supervisor / Co-investigator(s) / Student(s)**

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Josephine	Etowa	Health Sciences / Nursing	Supervisor
Ndolo	Njie-Mokonya	Health Sciences / Nursing	Student Researcher

File Number:

H11-12-09

Type of Project: Master's Thesis**Title:**

Exploring the meaning of Internationally Educated Nurse (IEN) experience as Registered Nurses within the Canadian Health Care System

Approval Date (mm/dd/yyyy) Expiry Date (mm/dd/yyyy) Approval Type

04/16/2013

04/15/2014

Ia

(Ia: Approval, Ib: Approval for initial stage only)**Special Conditions / Comments:**

N/A

Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g., change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: <http://www.research.uottawa.ca/ethics/forms.html>.

Please submit an annual status report to the Protocol Officer four weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: <http://www.research.uottawa.ca/ethics/forms.html>.

If you have any questions, please do not hesitate to contact the Ethics Office by e-mail at: ethics@uOttawa.ca.

Appendix G – CONFIDENTIALITY AGREEMENT

Title: Exploring the Integration Experiences of Internationally Educated Nurses (IENs) within the Canadian Healthcare System.

I, _____, agree to keep confidential, all information that I may learn during the process of being a critical reader of the thesis study named above.

Reader's Name

Reader's Signature

Researcher Signature

Date

Appendix H – LIST OF COUNSELLING RESOURCES

1. Algonquin College Internationally Educated Nurses Assessment Office – Ottawa, Ontario; Tel: (613) 727-4723.
2. Care Centre for Internationally Educated Nurses, Toronto; Tel: (416) 226-2800.