

Beyond Transition: Understanding Workplace Integration of Internationally Educated
Nurses - A Qualitative Case Study

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Abstract

Internationally Educated Nurses (IENs) have been proposed as one solution to dealing with the nursing shortage in Canada. In addition to helping sustain the profession, IENs are reflective of the diverse patient populations in Canada. Investments will ensure healthy workplaces for and retention of IENs. There has been a growing interest about IENs' experiences with migration and navigating through the regulatory process, but research on their post-transition experience is lacking. Workplace integration for IENs is not well understood and the role of the employer has received limited focus. Guided by critical social theory, an instrumental qualitative case study approach was used to examine a single organization, St. Michael's Hospital, Toronto, with a history of supporting IENs. A purposeful sample of twenty-eight participants included diverse IENs who were post-transition, and stakeholders from various vantage points. Four forms of data collection were used: semi-structured interviews; socio-demographic survey; review of documents and focus groups. Thematic analysis was carried out to form a within subcase analysis first, followed by an across subcase analysis. The major themes are: (a) when "integrated", an IEN is (i) being a "Canadian nurse with international experience"; (ii) progressing on the leadership journey; and (iii) persevering in overcoming challenges; (b) organizational factors that influence workplace integration of IEN are (i) workforce diversity; (ii) leadership commitment to equity; (iii) policies promoting equity principles; (iv) engagement with the broader community; and (v) avoiding common pitfalls. This research offers a definition and conceptual framework where workplace integration of IENs is a "two-way" process within an inclusive and valuing context, producing changes both at the IEN as well as organizational levels.

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List of Abbreviations

BPG	Best Practice Guideline
CCR	Canadian Council for Refugees
CEO	Chief Executive Officer
CHHRN	Canadian Health Human Resources Network
CIHI	Canadian Institute for Health Information
CNA	Canadian Nurses Association
CIC	Citizenship and Immigration Canada
CINAHL	Cumulative Index of Nursing and Allied Health Literature
CST	Critical Social Theory
ERCOMER	European Research Centre on Migration and Ethnic Relations
HR	Human Resources
ICU	Intensive Care Unit
IEN	Internationally Educated Nurse
IEP	Internationally Educated Professional
LGBTQ	Lesbian, Gay, Bisexual, Transgendered and Queer
NHS	National Health Service (in the UK)
OCASI	Ontario Council of Agencies Serving Immigrants

REB	Research Ethics Board
RPN	Registered Practical Nurse
RN	Registered Nurse
RNAO	Registered Nurses Association of Ontario
SMH	St. Michael's Hospital
UK	United Kingdom
UNHCR	United Nations High Commission on Refugees
US	United States

Chapter 1 - Introduction

Canada requires a continuous influx of internationally educated nurses as the annual number of graduates from Canadian schools of nursing is not keeping up with the numbers of nurses who are retiring or leaving the profession (CIHI, 2015; CNA, 2009). Canada had an estimated shortage of 11,000 registered nurses (RNs) in 2007, with a projected shortage of 60,000 by the year 2022 (CNA, 2009). In Ontario, a 10-year analysis for 2002 to 2011 suggested that the province is barely replenishing its supply of RNs (Valiani, 2012). Furthermore, Ontario has the second lowest RN-to-population ratio nationwide (RNAO, 2015). In order for Ontario to catch up to rest of Canada, at 2014's population level, an estimated 16,659 RNs would have to be added to the provincial nursing workforce (RNAO, 2015).

Internationally Educated Nurses (IENs) are considered one of the solutions to dealing with the nursing shortage in Canada and elsewhere. IENs are registered nurses who have obtained their basic nursing education in a country different from the one in which they are practising (Lum, 2009; Xu & Kwak, 2007). According to data analyzed by the Canadian Institute for Health Information (CIHI), there were a total of 348,407 nurses (including registered nurses, registered practical nurses and licensed practical nurses) in the Canadian nursing workforce in 2010 (CIHI, 2012). About 7%, or 25,273, of the nurses in the Canadian workforce in 2010 had graduated from an international nursing program; in Ontario, IENs made up over 12% of the nursing workforce in the province (CIHI, 2012).

In addition to helping sustain the profession, IENs come from places that are reflective of the increasingly diverse patient populations across Ontario and other parts of Canada. The 2012 immigrant landing statistics from Citizenship and Immigration Canada (CIC), indicate that the top three source countries for IENs destined for Ontario were the Philippines, India and

China. Furthermore, IENs enter Canada primarily as permanent residents with the objective of settling with their families and making Canada their new home (CIC, 2012).

There are significant personal, social, emotional and financial costs incurred by IENs as they go through the processes of migration, obtaining nursing registration or licence, finding employment and transitioning into the nursing workplace (Adams & Kennedy, 2006). Despite all of their struggles, IENs have been found to be a stable pool health human resource that is making an important contribution, and for whom further investments are needed in order to ensure long-term retention (Ibitayo, 2010; Xu & Kwak, 2007).

While investments have been made by governments and employers towards initiatives that support the orientation and transition of IENs into the profession (Kingma, 2007), there is a lack of research on their long-term post-transition phase (Adams & Kennedy, 2006). Furthermore, the concept of workplace integration for IENs is not defined or well understood within nursing (Covell, Neiterman & Bourgeault, 2014)

Using a qualitative case study methodology informed by critical social theory, this research makes an important contribution to nursing knowledge by focusing on IENs who are beyond their transition phase. In addition to post-transition IENs, other stakeholders within the workplace were interviewed to gain an understanding of what is meant by ‘integration’ and how it is influenced by the organizational context.

Chapter 1 provides the background and significance of the need to better understand workplace integration of IENs. In addition, my philosophical and epistemic stance, as well as the objectives and questions for this research, are also included.

1.1 Statement of the Problem

For more than a decade, there has been a growing interest in the nursing literature about IENs, including six reviews within the last six years (CHHRN, 2013; Freeman et al., 2012; Newton et al., 2012; Zizzo & Xu, 2009; Tilley, 2007; Xu, 2007). The nursing and healthcare literature on integration of IENs is mostly out of the UK, US, Australia and Canada. The literature can be categorized as follows: (i) system level policy and ethical issues in recruitment of IENs to address the health human resource planning challenges in high-income countries; (ii) organizational factors, including transition supports or programs for IENs, and (iii) individual level or experiences of IENs while going through the regulatory process to achieve registration and when transitioning into their new nursing workplace. While the term ‘workplace integration’ is used readily in reference to IENs, including in titles of publications, a definition is not provided.

Commissioned by the International Council on Nurse Migration, Adams and Kennedy (2006) proposed a policy framework to support the integration of IENs globally. They argue that while numerous transition programs have been implemented, the research into IENs’ experiences still raise concerns with regards to their success in the short term, and there is also a lack of research on the long-term post-transition phase. Adams and Kennedy (2006) explain that transition supports appear to be ad hoc and that systematic organization-wide efforts are necessary to develop more inclusive environments through public awareness and cultural competency training for staff; however, in organizations, these must be:

... part of a larger plan that includes the organizational philosophy, strategic priorities, policies and practices, employee and patient resources, multi-disciplinary approach, monitoring and evaluation, ongoing staff development and infrastructure of

accountability. There must be a “top-down” and “bottom-up” visible commitment to culture and diversity among employees and patients. (p. 31)

Adams and Kennedy (2006) submit that creation of positive practice environments not only assists the integration of IENs, but also benefits nurses in the host organization. Positive practice environments contribute to a dynamic, high functioning team by valuing and using skills of all nurses, resulting in culturally competent quality care for diverse patient groups. Despite its importance, this seminal work from the International Centre on Nurse Migration also lacks a definition of ‘workplace integration’ in the context of IENs.

The discourse from immigrant and refugee studies, however, offers several definitions on integration of immigrants and refugees discussed within the broader context of country level philosophies about immigration. The United Nations High Commission on Refugees (2005) defines integration as:

...a dynamic and multifaceted two-way process, which requires efforts by all parties concerned, including a preparedness on the part of refugees to adapt to the host society without having to forego their own cultural identity, and a corresponding readiness on the part of host communities and public institutions to welcome refugees and to meet the needs of a diverse population.

This view of integration as a “two-way” process highlights the need for the host community to change its norms, values and beliefs in order to embrace the newcomers (UNHCR, 2005). This way integration becomes a process for eliminating barriers to acceptance, belonging and recognition for immigrants and refugees (Omidvar & Richmond, 2003). Integration is also a goal for full and equal participation by immigrants and refugees with achievements in their social, cultural, political and economic domains of life (CCR, 1998).

The notion of integration as a two-way process from the immigrant and refugee studies literature has not permeated into the nursing discourse about IENs. Although workplace integration is not defined, there are several themes in the nursing literature that imply what IENs

need to do in order to be “integrated”. In Canada, the importance for IENs to understand the healthcare system and the autonomous practice of nursing has been highlighted, along with knowledge of the roles and scope of other members of the multidisciplinary team, community and social programs, health technology, fluency of language, terminology, jargon, acronyms, non-verbal communication and culture-specific behaviours, to name a few (Adams & Kennedy, 2006; Blythe & Baumann, 2009; Bourgeault et al., 2010; McGuire & Murphy, 2005; Sochan & Singh, 2007; Tregunno et al, 2009). This understanding of what is required of IENs appears one-sided and is limited to the early orientation and transition phases. Raghuram (2007) argues that IENs are made to adjust to the host environment and that the two-way integration which should include IENs being allowed to influence the nursing practices of the host system, is not usually evident. Adams and Kennedy (2006) place the emphasis on the role of employers in undertaking systematic organization-wide approaches that create an inclusive, enabling climate that values the contributions of IENs.

In summary, developing a greater understanding of integration of IENs beyond the transition phase and within the context of the workplace organization will make an important contribution to nursing knowledge. This research addresses the current gaps by focusing on the experiences, achievements and contributions of IENs who have already adjusted and transitioned into the nursing environment in Canada. An emphasis on the organizational context explores workplace integration as a two-way process in nursing and thus generates insights for how employers can effectively facilitate workplace integration of IENs. Finally, a definition of workplace integration of IENs derived from this research could be the future basis for the tracking and measurement of this phenomenon.

1.2 Research Aim and Objectives

The overall aim of this research is to understand how IENs are integrated into workplaces beyond the transition phase. This research has the following objectives:

- To understand how IENs conceptualize their integration in the workplace.
- To explore what integration of IENs means to other stakeholders in the workplace.
- To understand how the organizational context influences workplace integration of IENs.
- To identify the key elements that promote and/or hinder workplace integration of IENs.

1.3 Epistemological Stance

I understand that as a researcher, my worldview and philosophy has an impact on all aspects of the research process – right from the choice of the research problem, to choices related to theoretical framework, context and methodology (Guba & Lincoln, 2005). While creating “distance” or “objective separateness” is not relevant in qualitative research, Creswell (2013) highlights the importance of declaring one’s position and being reflexive throughout.

My view of the world stems from my multiple social identities: South Asian, Ismaili Muslim, married woman and mother. I spent my formative years growing up in Tanzania, a former British, German and Portuguese colony. I immigrated to Canada as a young teenager and have undergone professional socialization as a public health nurse, health administrator, organizational development consultant in the not for profit sector, and most recently as a senior manager in a community based agency that aims to create access and equity for IENs settling in Ontario. I believe there are multiple realities that are shaped by social identities and power imbalances which stem from historical, sociocultural, political and economic conditions. These realities are not always evident or clear but they can become crystalized over time through

continued reflection and dialogue (Guba & Lincoln, 2005). I also believe that these realities are not objective or fixed; they are variable and continually negotiated in power dynamics between individuals and groups (Boutain, 1999), including as a result of research (Creswell, 2013).

My values and philosophical principles are grounded in issues of equity and access for marginalized populations, including racialized, immigrant and refugee communities. I have been involved in numerous initiatives focused on systemic and organizational change with the aim of addressing health and social inequities for diverse groups. Epistemologically, I have experienced the difference in outcomes when change processes ensure that silenced voices of marginalized groups are heard. Using participatory approaches that value the joint involvement of both service users and providers, I have witnessed how dialogue and interaction can effectively address power imbalances. I acknowledge the benefits of the co-creation of knowledge with diverse participants, including the transformative effects and the action or change agenda that emerges as a result.

In reflecting on this research on the workplace integration of IENs, a critical social theory (CST) framework resonates for me on multiple levels. The plethora of nursing publications on challenges related to IENs lacks a critical analysis of inherent power imbalances. IENs seem to be problematized by the notable absence of integration as a two-way process and a lack of emphasis on the responsibilities of the employer. While a definition of workplace integration of IENs has not been available, a CST lens applied to the domains of broader integration from the immigrant and refugee literature pointed to relevant areas of exploration in this study. Examples of areas explored include: IENs' opportunities for advancement and career mobility; fair and equal treatment by colleagues, managers, patients and families; feeling encouraged to share models of nursing from their former practice environments; and being able to influence nursing

practice in the workplace. A CST inquiry provides an understanding of workplace integration from IENs' and other stakeholders' perspectives, as well as an analysis of power relations. Knowledge that gets generated amplifies contributions by IENs and counteracts the prevailing deficit focus (Boutain, 1999). CST is effectively linked to case study methodology as the 'case' or point of analysis is the workplace as the social institution (Smith, 2005). The wider structures of the workplace 'case' are examined to illustrate how organizational commitment, or lack of it, shapes perspectives about IEN integration (Smith, 2005).

1.4 Summary

IENs are proposed to be one of the solutions to dealing with the nursing shortage and ensuring that the nursing workforce is reflective of the increasingly diverse patient population across Canada. Significant personal, social, emotional and financial costs are incurred by IENs, along with investments by governments and employers in supportive programs. There is, however, a lack of research on IENs' long-term progress. The concept of workplace integration for IENs is not defined, and the notion of integration as a two-way process from immigrant and refugee studies has not permeated into the nursing literature about IENs. A review of the literature confirms that developing a greater understanding of integration of IENs beyond the transition phase and within the context of the workplace organization will address current gaps in nursing knowledge. This research makes a specific contribution to nursing by offering a definition of workplace integration of IENs and a set of promising organizational practices that facilitate workplace integration of IENs. A qualitative case study informed by critical social theory is introduced as the preferred methodology for this research.

Chapter 2 – Literature Review

A comprehensive review of the literature was conducted for this study. Search themes such as “workplace integration of internationally educated/foreign trained nurses”; “experiences of internationally educated/foreign trained nurses”; “transition/adaptation supports for internationally educated/foreign trained nurses”; “organizational changes/initiatives to support diversity/internationally educated professionals”; “immigrant/refugee integration” – generated materials from the fields of nursing and immigrant and refugee studies using CINAHL (Ebsco), PubMed (Medline) and ProQuest search engines/databases. Gray literature has also played a significant role in this literature review, especially those taken from the initiatives of the Ontario Council of Agencies Serving Immigrants (OCASI) and the Ontario Hospital Association/Nursing Health Services Research Unit, McMaster University’s joint project regarding IEN integration.

The findings from the literature review are organized under two broad themes related to integration: firstly, as portrayed in the immigrant and refugee studies literature, and secondly, as discussed in literature specific to nursing. The nursing literature overlaps with the more general healthcare focus and is further presented according to discourse about integration of IENs at the system, organizational and individual levels.

2.1 Integration in Immigrant and Refugee Studies Literature

While integration of IENs is not defined in nursing, there are relevant and meaningful references to integration in the immigrant and refugee studies literature. Aside from definitions of integration, the immigrant and refugee studies literature also offers various dimensions or ways of thinking about integration. Both are outlined in the sections below.

2.1.1 Definition of integration.

Definitions in immigrant and refugee studies describe “integration” as a mutual, two-way process between the new home or host society and the newcomers (Castles et al., 2002; Hyndman, 2011; UNHCR, 2005; Wong & Poisson, 2008). Castles et al. (2002) state:

Integration is a two-way process of adaptation, involving change in values, norms and behaviours for both newcomers and members of the existing society. This includes recognition of the role of the ethnic community and the idea that broader social patterns and cultural values may change in response to immigration. (pp. 115-118)

Wong and Poisson (2008) submit that it is only sensible to think that the host community would want newcomers to be contributing members of society. To achieve that, immigrants must be able to participate. Federally, Citizenship and Immigration Canada articulates a deliberate intent behind its ‘Integration Program’ (CIC, 2013). It encourages a process of mutual accommodation and adjustment by both newcomers and the larger society (CIC, 2013). Ley (2005) explains that ‘integration’ attempts to signify a break with assimilation, particularly in a Canadian context where the Multicultural Act and the federal Charter of Rights and Freedoms “institutionalize not only respect for difference but also the rights of being different” (p. 7).

Within the immigrant and refugee services sector, even though integration is discussed as a two-way process, most programs seem to promote interactions among newcomers rather than with established immigrants or those born in Canada (Wong & Poisson, 2008). Omidvar and Richmond (2003) highlight that it is problematic that government funding has focused only on the initial stages of adaptation, even though the process of integration continues throughout the life of the newcomer and requires adjustments actions on the part of the host society as well. There is a paucity of literature on how communities reach out to immigrants and refugees and how they themselves adapt in the process of integrating newcomers (Hyndman, 2011). From a

research perspective, it is also pertinent to note that immigrants and refugees themselves have not been involved in defining successful integration (Hyndman, 2011).

2.1.2 Dimensions of integration.

The lack of a single, clear definition of integration has led to different views about what strategies promote successful integration, what do “integrated” individuals or groups look like or what are the characteristics of an integrated society (Hyndman, 2011). One understanding of integration is as a continuum with different stages – such as pre-migration, initial settlement, settlement, transition, full participation – each reflecting particular needs and issues faced by immigrants and refugees, and the types of services or supports that might be priority or appropriate (Birjandian, 2005).

Integration has also been considered as a process taking place at different levels, at the individual, group and institutional levels (Penninx, 2003). At the individual level the focus is on how well the individual immigrant is adapting to the new home community; at the group level, the unit of analysis is how the particular immigrant group or community is being accepted or rejected as part of mainstream society; at the institutional level, however, the emphasis is on the types and degrees of adjustments that public systems are making in order to ensure access to and equal participation of immigrants (Penninx, 2003).

The Canadian Council for Refugees (CCR) identifies nine underlying principles for programs and services designed to promote immigrant integration: accessibility, inclusion, client empowerment, user-defined services, respect for the individual, cultural sensitivity, accountability, orientation towards positive change, and reliability (CCR, 1998). Integration is discussed as a complex and long-term process with outcomes in four main spheres or domains: cultural, political, social and economic (CCR, 1998). Within each domain, the speed and degree

of integration can vary and what happens in one affects the outcome in the others; for example, progress economically can allow for easier social and cultural integration (CCR, 1998). Indicators are one way to assess or track the degree of integration; Table 1 provides some examples that are useful to evaluate newcomers' and society's level of integration (CCR, 1998).

Table 1 *Some Indicators of Settlement and Integration according to Domains*

Domains	Short term (settlement)	Longer term (integration)
Economic	• entering job market • financial independence	• career advancement • income parity • entry into field of prior employment
Social	• established social network • diversity within social network	• accessing institutions • engaging in efforts to change institutions
Cultural	• adaptation of various aspects of lifestyle (e.g. diet, family relationships)	• engaging in efforts to redefine cultural identity • adapting or reassessing values
Political	• citizenship • voting	• participation in political parties • participation in socio-political movements

(CCR, 1998)

Caidi and Allard (2005) state:

...without mechanisms in place to ensure that newcomers are adequately integrated in their newly adopted society, these groups may be at greater risk of being pushed to the margins of the democratic process, or feel isolated and lacking opportunities and choice. (p. 1)

When applied to IENs (see Appendix I), one of the main limitations of CCR's domains model is that IENs' experiences of integrating in the social, cultural, economic and political domains of their lives may have a bearing on how they think or view their progress in the workplace. In addition, IENs' historical backgrounds of coming from colonized countries as well as any

oppressive experiences during migration and settlement processes might limit their perspectives.

Georges (2003) states:

...marginalized groups often adopt the dominant discourse into their own context, in a conscious attempt to seem more acceptable to the dominant group and therefore perpetuating the hegemonic discourse reinforcing the power of the dominant group and maintaining the oppressive status quo. (p. 50)

The European Research Centre on Migration and Ethnic Relations (ERCOMER) has added attitudes among members of the host community as another focus to its set of benchmarks for successful integration (Entzinger & Biezeveld, 2003). ERCOMER argues that perceptions of immigrants and immigration in the host society are critical to building inclusive communities (Entzinger & Biezeveld, 2003). Pillai et al. state that the level of involvement and understanding of the host community towards immigrant integration can be achieved through strategic partnerships, effective communication with the local community, and ongoing research to inform policy making (as cited in Wong & Poisson, 2008).

In all of the discourse about immigrant and refugee integration, it is easy to overlook one important issue - measures of integration are against an ideal and so the question arises: who, in fact, achieves this ideal (CCR, 1998)? According to the CCR (1998), one of the key principles of immigrant and refugee integration is the freedom and choice to participate as desired rather than having to meet expectations that do not apply to the Canadian-born or more established Canadians. In other words, while indicators of integration are proposed for immigrants and refugees, are there expectations about how “integrated” the average Canadian is in terms of economic, social, political, and cultural participation (CCR, 1998)?

2.2 Integration in Nursing and Healthcare Literature

The nursing and healthcare literature on integration of IENs is mostly out of the UK, US, Australia and Canada. It can be organized into three categories: (i) system level policy and ethical issues in recruitment of IENs to address the health human resource planning challenges in high-income countries; (ii) organizational factors including transition supports or programs for IENs; and (iii) individual factors conveyed through studies about experiences of IENs while going through the regulatory process to achieve registration and when transitioning into the nursing workplace. The sections below summarize key findings from literature focused at these three levels.

2.2.1 System level - policy and ethical issues pertaining to IEN recruitment.

International migration of nurses is now part of a common global trend of movement of workers (Kingma, 2007). Several “push” and “pull” factors resulting in international migration of nurses are discussed by Buchan (2006). Structural adjustments in developing countries have resulted in large numbers of unemployed professionals, including nurses, thereby creating a push factor (Kingma, 2007). For supplying countries like the Philippines, there is an economic benefit from the large sums of remittances that nurses and other professionals send back home to their families (Buchan, 2006). There is also the hope or possibility of greater skills and qualifications upon the return of these exported workers back to the Philippines (Buchan, 2006). Aside from the need for employment, nurses also migrate because of their desire for a better quality of life, opportunities for professional development and attaining additional skills and education, a better income, meeting family responsibilities such as providing for children, and personal security and safety from civil instability or war, as well as from occupational hazards (Kingma, 2007). Concerns about the imbalances that are created when nursing resources from developing

countries shift to developed countries are well articulated (Buchan, 2006; Kingma, 2007) in position statements by international and national nursing associations (Adams & Kennedy, 2006). Given the various push and pull factors that are at play, it is difficult to predict patterns of nurse migration.

There have been numerous concerns about lack of fairness, discrimination, racism and abuse towards IENs in various jurisdictions (Adams & Kennedy, 2006). Although codes of ethical practice are available to destination countries to guide foreign nurse recruitment practices, such as the *Commonwealth Code of Practice for the International Recruitment of Nurses*, they are seldom used (Labonté et al., 2006). A qualitative study performed by Pitmann et al. (2012) in the US found that IENs experienced labour, contract, and immigration problems, and that the agencies and employers who recruited them were largely unregulated. A group of health care organizations, the Alliance for Ethical International Recruitment Practices, has now issued guidelines for employers and recruiters of internationally educated nurses and health professionals in the US *The Voluntary Code of Ethical Conduct for the Recruitment of Foreign-Educated Health Professionals to the United States* seeks to protect internationally educated nurses from exploitation and abuse and to define the minimum standards of treatment (Alliance for Ethical International Recruitment Practices, 2011). Nursing unions and some nursing advocacy organizations have argued that because the nursing shortage results from underlying problems - poor working conditions and inadequate pay - that led many qualified nurses to leave the field in the first place, importing foreign workers is not a lasting solution (Stubenrauch, 2008). Kingma (2007) also submits that “injecting migrant nurses into dysfunctional health systems - ones that are not capable of attracting and retaining staff domestically - will not solve the nursing shortage” (p. 1281).

While debates on global nurse migration include ethical concerns and the effects of nurse migration on the developing world, ultimately it is an individual's right to choose to migrate (Kingma, 2007). Professional nurses who migrate may choose to remain employed long term in the destination country, relocate to another country, or return to their source country (Buchan, 2006). Until recently, it has been assumed that migration means that people move to destination countries once and for all (Haour-Knipe & Davies, 2008). However, this is beginning to change, with increasing attention being paid to migrants returning to their homelands and how “the return of innovation” can bring positive change to the migrant's country of origin (Haour-Knipe & Davies, 2008, p. 2).

In Canada, four provinces (British Columbia, Alberta, Saskatchewan and Manitoba) have bilateral agreements with the Philippines to recruit IENs and other migrant workers (Blythe et al., 2009; Conference Board of Canada, 2013). Kolawole (2009) argues that the ethical challenge of “brain waste” or the waste that comes about when IENs, as newcomers, are unable to have their knowledge and skills recognized or because of difficulties in workplace integration – is an important issue and requires more attention in Canada (p.185).

2.2.2 Organizational factors.

The literature provides insights on supports for IENs in the early transition phase. Also, there is promise in creation of positive practice environments which respect diversity of their staff and are inclusive in their organizational policies and behaviours.

2.2.2.1 Transition supports for IENs.

Definitions of ‘transition’ vary between healthcare disciplines but they generally involve people's responses during a passage of change. Transition occurs over time and entails change and adaptation, for example developmental, personal, relational, situational, societal changes; the

reconstruction of a valued self-identity is essential to transition (Kralik, Visetin & Van Loon, 2006). Yi and Jezewski (2000) found that IENs' transition occurs in two stages: an initial adjustment taking two to three years, followed by an additional five to ten years for full adjustment to the work environment. Neiterman and Bourgeault (2015) suggests that since students have four or more years of study to be socialized, internationally educated health professionals, including IENs, also need time for resocialization in their professions. Ibitayo (2009) argues that for an IEN, professional satisfaction indicates the end-stage of that individual's transition experience.

A systematic review of transition programs providing support for IENs post-hiring was conducted by Zizzo and Xu (2009). Of the twenty programs reviewed, none were Canadian; nine had a mentorship component, but only four were voluntary; ten indicated the importance of language and communication courses but only five actually included a language course; the length of the formal program ranged from one week to one year, with most being twelve to sixteen weeks; finally, there was minimal research and evaluation on the effectiveness of these programs (Zizzo & Xu, 2009).

In Ontario, there is an attempt to apply the health human resource policy experience of the New Graduate Guarantee initiative, to the integration of IENs (Baumann, Hunsberger, Crea-Arsenio & Idriss-Wheeler, 2012), recognizing that they have significantly different realities. IENs are entering the workforce as experienced nurses, with a higher average age and more life experiences, including that of having migrated from different source countries and settling as newcomers in Canada. In the context of new nursing graduates, integration is viewed as a process by which they enter the workforce effectively and efficiently, including being prepared for independent practice and adapting to the culture of the organization (Baumann, Hunsberger

& Crea-Arsenio, 2011). While this perspective offers some potential indicators of integration of IENs, the focus remains on the early adaptation phase and with the primary responsibility placed on the IEN.

Several other transition strategies that provide direct and indirect support to IENs are recommended in the literature. Lum (2009) has highlighted the importance of assessing the learning style of the IEN participants of transition programs so that learning is maximized. As newcomers settling in the broader community, opportunities for cultural connection and peer networks could provide some essential support for IENs transitioning into their new practice settings (Ager & Strang, 2008; Sochan & Singh, 2007). A study by Sherman and Eggenberger (2008) showed that unit managers were crucial to the IEN's successful transition into the work environment and achievement of professional satisfaction. Drach-Zahavy found that when nursing leaders behave in a supportive way, other nurses take the cue from them and follow suit (as cited in Tilley, 2007). Hoxby et al. (2010) recommend that nursing supervisors and managers should be provided training on managing diverse teams, thereby creating an environment which is supportive and inclusive of IENs. Liou and Cheng (2009) compared perceptions of practice in the US with Asian IENs and Asian nurses educated in the US. They found that supportive managers, a safe working environment, and collegial relationships with staff and physicians, positively influenced perceptions of practice (Liou & Cheng, 2009).

2.2.2.2 Positive practice environments.

Adams and Kennedy (2006) state that in order to promote IEN integration, a systematic organization-wide approach with changes at all levels is required to bring about inclusive workplace practices. In the UK, the National Health Service (NHS) Employers established a framework for developing and implementing positive action initiatives to achieve long-term

integration of diverse employees, including IENs (NHS Employers & University of Bradford, 2005).

Table 2 *Positive Action - Key Success Factors and Best Practices*

Organizational Culture Support for diverse workforce at all levels Celebrating Success Thinking outside the box and taking calculated risks Being flexible and adaptable
Leadership Passion and drive Commitment from the top and across the organization Team working Perseverance
Communication Knowing the local communities (consultation and engagement) Sharing good practice Marketing within the organization
Strategic Management Approach Strategic framework Sound planning Managing expectations Local partnerships Monitoring
Resources Long term funding Dedicated posts Targeted resources Project management

(NHS Employers & University of Bradford, 2005)

Best practices corresponding to key success factors (Table 2) such as organizational culture, leadership, communication, strategic management approach and resources are identified in this framework (NHS Employers & University of Bradford, 2005). Feeling valued is one of the most important factors to support integration (Walker, 1994) and so the fundamental framework to support IENs is based on treating them fairly with respect and dignity (Adams & Kennedy, 2006). Adams and Kennedy (2006) also argue that positive practice environments not only support integration of IENs, but also benefit all nurses/team members as a whole.

The notions of positive practice environments for nurses and positive action framework developed in the UK are also reflected in parallel works in Canada. The Healthy Work Environments for Nurses Project (RNAO, 2007) in Ontario is described next.

2.2.2.3 Healthy work environments for nurses – best practice guidelines.

A series of six Best Practice Guidelines (BPGs) were developed by the Registered Nurses Association of Ontario (RNAO) as part of its Healthy Work Environments for Nurses Project (RNAO, 2007). The aim of these guidelines is to “provide the best available evidence to support the creation of thriving work environments” (p. 1); the basic premise is that positive and healthy workplace conditions for nurses yield better health outcomes for patients/clients. Aside from guidelines for collaborative practice, staffing and workload practices, leadership, professionalism and workplace health and safety, the specific guideline for *Embracing Cultural Diversity in Health Care: Developing Cultural Competence* is of special relevance.

A “culturally competent” health care organization is described as one that embraces cultural diversity via a commitment to practices and strategies that eliminate discrimination and disparity; it has a congruent set of workforce behaviours, management practices and institutional policies, leading to a respectful, inclusive environment. The underlying values of the

organization include inclusivity, respect, valuing differences, equity and commitment (RNAO, 2007). The BPGs call for organizations to engage in deliberate change processes which are planned and facilitated with dedicated resources and administrative supports. The BPGs includes several recommendations at three levels: individual, organizational and external policy context. At the organizational level, the recommendations focus on creating an inclusive and safe environment for staff from diverse backgrounds and to implement strategies to recruit as well as retain diversity in the nursing workforce. The BPG acknowledges that IENs are one way of ensuring a diverse nursing team and organizations need to support them specifically (RNAO, 2007). Upon implementation of these recommendations, the anticipated outcome of a culturally competent workplace is summarized as: “Where all employees experience cultural safety, diversity is celebrated, the atmosphere encourages curiosity, creativity, innovation, and engagement, and there are no systemic barriers affecting hiring and retention of employees” (RNAO, 2007, p. 37). Organizations striving to become culturally competent are also working on deliberate ways to become inclusive. The next section draws on various experts’ perspectives related to building inclusive organizations.

2.2.2.4 Building inclusive organizations.

The broader goal of becoming diverse and inclusive is an ongoing organizational process (Ontario Healthy Communities Coalition, 2004). According to Allen (2006), the terms “multiculturalism” or “diversity” can unfortunately often imply that a bunch of “other” people need to be taken into the mainstream organization; or the approach of many “diversity” recommendations is primarily one of “add colour and stir” (p.66). Inclusion refers to the systemic nature of an organization, and to achieve it, workplaces have to create policies and practices that recognize more than one view and that signal the importance of learning from

differences (Bormann & Woods, 1999). Inclusive organizational environments are conducive to critical analysis and encourage self- reflection and self-determination (Getty, 2010; Manias & Street, 2000; Roberts, 1983). Organizations that work on inclusion deliberately allow for full and equal participation by everyone (Saloojee, 2003).

As put forward by Bormann and Woods (1999), the underlying premise of The Workplace Diversity Network at Cornell University's *A Framework for Building Organizational Inclusion*, is that it is possible for organizations to be inclusive and not diverse, and vice versa. Bormann and Woods further argue that in order to maximize organizational achievement, both diversity and inclusion are essential. They go on to present a framework that lists the main attributes of inclusive workplaces, shown in Table 3, together with policies and practices that support these attributes. Some of the key aspects highlighted by the Borman and Woods framework is that the inclusive organization is pictured as a participatory environment with: (i) open communication; (ii) a commitment to diversity; (iii) continuous learning; (iv) community relationships; (v) a holistic view of its employees; and commitments to (vi) accommodate diverse abilities and (vii) create access to opportunities. Finally, an inclusive organization demonstrates shared responsibility and accountability and strives for equitable systems for reward and recognition (Bormann & Woods, 1999).

A potential pitfall of a systematic organizational approach to becoming inclusive of IENs and other individuals of diverse backgrounds is when there is no dialogue about issues of race and gender discrimination in order to determine what changes are meaningful (Boutain, 1999; Hagey et al., 2001; Kersten, 2000; Minors et al., 1995; Nussbaum, 2005). Kersten (2000) cautions about the use of an inclusive definition of diversity, in which any and all differences (e.g. gender, age, race, socio-economic status, sexual orientation, abilities, etc.) are considered in

an attempt to appeal to a broad audience. She states that this broad appeal comes at the cost of avoiding and minimizing structural and institutional forms of discrimination, and despite extensive efforts, if the dialogue related to race is not explicit, marginalization, problematization and other painful experiences will continue to exist. There is a risk then that organizational inclusion can be in disguise such that when IENs, or other peoples “of difference”, are invited in, it is the IENs and not the organization that is made to change.

Table 3 *Attributes of Inclusive Organizations*

Demonstrated Commitment to Diversity
Holistic View of the Employees and the Organization
Access to Opportunity
Accommodation for Diverse Physical & Developmental Abilities
Equitable Systems for Recognition, Acknowledgement & Reward
Shared Accountability and Responsibility
360 Degree Communication and Information Sharing
Demonstrated Commitment to Continuous Learning
Participatory Work Organization and Work Process
Recognition of Organizational Culture and Process
Collaborative Conflict Resolution Processes
Demonstrated Commitment to Community Relationships

(Bormann & Woods, 1999)

2.2.2.5 Anti-racist organizational change.

To avoid risks of diluting the focus, an organizational change approach that is clearly labelled as” anti-racist” is proposed (Lopes & Thomas, 2006; Minors et al., 1995). Minors et al. (1995) define racism as “when intentionally or not, power is exercised by individuals or institutions in such a way that the impact is that racialized peoples have unequal access to decision-making and resources” (p. 5). They explain that individual racist attitudes and behaviours are not confined to white people but that all racialized groups are just as susceptible and may act on their prejudices at an individual level (Minors et al., 1995). Anti-racist organizational change examines and transforms an organization’s staff, structure, strategy and services to ensure that power is not used to preserve the advantage of one racialized group relative to another (Lopes & Thomas, 2006; Minors et al., 1995). Table 4 portrays Minors et al.’s (1995) model – a continuum that ranges from organizations at one end being exclusive and discriminatory, to the other end where they are inclusive and anti-discriminatory.

Table 4 *Contemplating Change - From Exclusive Club to Inclusive Organization*

Value the dominance and worth of one race, cultural group, communication style, etc.			Value the equality, worth and contributions of all races, cultures, groups, etc.		
Transition - Transformation					
1 Exclusive Club	2 Denial “We have no problems”	3 Resistance “What do they want?”	4 Tokenism “We celebrated Diwali and Hanukkah too!”	5 Acceptance “We will challenge racism in all forms and take affirmative measures”	6 Inclusive Organization
Discriminatory			Anti- Discriminatory		

(Minors et al., 1995)

The anti-racism change process requires senior leadership commitment to undertake an organization-wide process to develop a plan for change with the aim to move the organization along the continuum to become inclusive (Minors et al., 1995).

Anti-racism organizational change processes are also inherent in other frameworks that examine change at the personal and systemic policy levels. McGibbon and Etowa (2009) outline three processes that are important for healthcare professionals to understand in order to guide their anti-racist practice: (i) seeing and acknowledging or becoming aware of the paths from stereotype to oppression – how certain stereotypes can lead to thinking and behaving in certain ways; (ii) understanding and connecting racism to the policy arena results in an analysis of how racism is embedded in structures and can be sustained over time; and (iii) acting for social change refers to moving beyond being aware and analyzing, to actually impacting specific change targets:

2.2.3 Individual factors - challenges faced by IENs.

Migration to another country has been well documented as a major stressor for IENs (Kingma, 2007). While family and friends already in the destination country encourage nurse migration, nurses are often caught in the situation of choosing to either emigrate with their immediate family members or place their children in the care of a relative in the source country (Kingma, 2007). Buchan (2006) found one third of emigrating nurses with children had to leave their children in the source country. Aside from the separation from family and friends, IENs may face abuse, exploitation, discrimination and unfairness during the process of immigrating (Adams & Kennedy, 2006; Blythe & Baumann, 2009).

The process of getting credentials assessed and meeting the regulatory requirements for registration or licensing as a nurse in the destination country can be a long, frustrating and

painful journey. There are numerous issues related to: accessing timely, accurate and accessible information; the cost of the various stages of the application and registration process; achieving the language proficiency benchmarks; orientation to the role of the nurse and interdisciplinary team, familiarity with the healthcare system; and the cultural context of diverse or heterogeneous patient populations (Blythe & Baumann, 2009; Bourgeault et al., 2010; ; McGuire & Murphy, 2005; Sochan & Singh, 2007; Tregunno et al, 2009).

A comprehensive literature review conducted by Newton, Pillay and Higginbottom (2012) resulted in five common themes: reasons for and challenges with immigration, cultural displacement, credentialing difficulties and deskilling, discriminatory experiences and strategies for IENs which smoothed transition. Their study highlights that the huge advantages in professional skill and cultural diversity that IENs can bring to any nursing unit will not be fully realized without substantial efforts to reduce practice limitations (deskilling) and discrimination.

A study of overseas Black and ethnic nurses in the UK revealed eight themes: not feeling appreciated, feeling inadequate, feeling unwelcome, lack of opportunities for skill development and training, unfairness in nursing practice, performance review, support from overseas Black and minority ethnic colleagues and proving self (Alexis & Vydelingum, 2005). IENs' experience of discrimination, racism or mistreatment has been a theme in several other studies as well (Allan, 2010; Batnitzky & McDowell, 2011; DiCicco-Bloom, 2004; Hawthorne, 2001; Kawi & Xu, 2009; Magnusdottir, 2005; Mapedzahama et al., 2012; Pizer et al., 1992; Turriffin et al., 2002; Zhou et al., 2011). These experiences of IENs also resonate with studies done on Black nurses in Ontario (Das Gupta, 2009) and in Nova Scotia (Etowa et al., 2009).

A study of Korean nurses' adjustment to nursing in the US revealed five major categories of concerns that were prominent over two phases: during the first two to three years, relieving

psychological stress, overcoming the language barrier and accepting US nursing practice were the major issues. The second phase took five to ten years from the time the nurses had started practising in their new environment, and included adopting the styles of US problem-solving strategies and interpersonal relationships as the main concerns (Yi & Jezewski, 2000).

Ibitayo (2009) discussed how the family, social and work environments post-migration interact with the transition conditions to influence the IEN's professional satisfaction in their current job. Professional satisfaction is defined as "career choice and meaningfulness of work within one's life goals" (Lynn & Redman, 2005, p. 266). Investing in family and work life increases job satisfaction and promotes adaption to a new environment (Hayne, Gerhardt & Davis, 2009).

Xu's (2007a) meta-synthesis of fourteen studies on transition experiences of immigrant Asian nurses in Western countries identified four overarching themes: (i) communication as a daunting challenge, (ii) cultural differences, (iii) marginalization, discrimination and exploitation, and (iv) differences in nursing practice. He argues that since transition means change in its broadest sense, in the case of Asian nurses working in Western countries, transition can be defined as modifications in behaviors and thinking - adaptation and acculturation (Xu, 2007b). Xu (2007b) goes on to argue that the transition process is highly complex, and that it may take IENs years to achieve.

2.3 Workplace Integration for IENs - Emerging Definition and Conceptual Framework

Based on the review and critique of the literature, the following is the definition of workplace integration of IENs which emerged for me at this stage in the research:

Workplace integration of IENs is a long term and complex two-way process, involving a systematic organization-wide commitment to diversity and inclusion,

which allows for full and equal participation by IENs, resulting in specific achievements at both the individual and organizational level. Outcomes of effective integration are evident in the economic, social, cultural and political domains of IENs' work life.

The emergent definition provides nursing with a vision of what IENs' workplace integration can be, both at the organization and the IENs' levels. The organization is inclusive in all respects, and this way, barriers to fairness, equity, acceptance, belonging and participation are eliminated. That is, IENs who are immersed in such a workplace have: equal opportunities for career advancement and mobility; they experience fair and equal treatment by colleagues, managers, patients and families; they are valued and encouraged to share models of nursing from their former practice environments; and they are able to influence nursing practice in their workplace. Furthermore, the definition provides parameters for specific outcomes that could be monitored and tracked so as to minimize the risk of IENs being excluded from organizational processes and from being "pushed to the margins" (Caidi & Allard, 2005, p. 1).

Building on the proposed definition, the conceptual framework (Figure 1) depicts interaction of key elements necessary for achieving workplace integration of IENs. Practices favouring dominant groups within the workplace could create social closure and exclude IENs from organizational processes (Roscigno et al., 2007). Deliberate efforts to develop the IENs' workplaces into more inclusive environments have been emphasized as the key to facilitating IENs' longer-term integration (Adams & Kennedy, 2006). Inclusion refers to the systemic nature of an organization, and to achieve it, workplaces have to create policies and practices that recognize more than one view and that signal the importance of learning from differences (Bormann & Woods, 1999).



Figure 1 Conceptual Framework for Workplace Integration of IENs

The broader goal of becoming inclusive is an ongoing organizational process, and requires first most, a clear vision and commitment at the senior leadership levels (Ontario Healthy Communities Coalition, 2004). As in most contexts of organizational change, Drach-Zahavy found that when nursing leaders behave in a supportive way, other nurses take the cue from them and are also supportive (as cited in Tilley, 2007). A “top-down” and “bottom-up” visible commitment is critical for systematic organization-wide change to become inclusive (Adams & Kennedy, 2006). The organizational leadership is passionate and driven about building an inclusive workplace such that there is buy in and commitment from teams across the organization. Aside from fostering participation and team work, the organizational culture values open dialogue and diverse perspectives, thinking outside the box and taking calculated risks (NHS Employers & University of Bradford, 2005). The inclusive organizational environment is

conducive to critical analysis and encourages self-reflection and self-determination (Getty, 2010; Manias & Street, 2000; Roberts, 1983). In this sense the organization is open to continuous improvements to existing structures or systems that may be creating social closure or are exclusionary for specific groups (Roscigno et al., 2007).

A priority area where exclusionary practices may be subtle and covert is the area of human resource policies and practices. The goal of having a diverse workforce at all levels of the organization is frequently not attained unless affirmative action approaches are deliberately implemented (Minors et al., 1995). A critical analysis is required in order to determine how power imbalances and social closure are addressed, and the type of supports that are in place to ensure that incumbents are set up for success (Minors et al., 1995; Roscigno et al., 2007). While formal and informal hierarchies exist in all social contexts, they may not be readily understood by newcomers or “outsiders” (Nussbaum, 2005). A safe climate to ask critical questions that reveal decision-making mechanisms for how “rules” in the form of policies, written and unwritten, have come about and how they affect different groups is cultivated continuously within this framework (Nussbaum, 2005).

Targeted resources for facilitating and managing the change process are committed to and “earmarked” over a realistic term by organizations committed to inclusion (NHS Employers & University of Bradford 2005). Strategic management is evident, including sound planning with targeted outcomes, and mechanisms for monitoring and tracking changes (NHS Employers & University of Bradford 2005). Given the long term and incremental nature of this type of change, particular attention is paid to managing expectations and celebrating successes (Minors et al., 1995). Resources are not just economic, but also personal and social and can influence interactions and outcomes, including information, control over meanings and access to networks

(Nussbaum, 2005). Strategies to promote communication, sharing of promising practices and networking are continually implemented, evaluated and readjusted (NHS Employers & University of Bradford 2005). While there is acknowledgement of those who are participating in processes, there is an equal or greater emphasis placed on those who are “not at the table” or “being left out”. Inclusive organizations recognize that needs for resources vary among people, at various times and according to capabilities; to be equitable, workplace policies or systems are considerate of the need for differential supports for diverse staff, including IENs (Minors et al., 1995).

Organizations that work on inclusion through a systematic organization-wide process achieve specific gains that are necessary for the two-way integration experience in the context of IENs’ workplaces. On an organizational level, inclusion promotes fairness and equity, there is valuing of the contributions of everyone, and it allows full and equal participation by all (Saloojee, 2003). At the level of the IENs, the inclusive workplace provides IENs with a sense of belonging, recognition and acceptance; all pre-requisites for IENs to be able to fully and equally participate in all aspects of organizational life (RNAO, 2007; Omidvar & Richmond, 2003; Schultz & Sankaran, 2006). Examples of this may include IENs accessing professional development opportunities, engaging on committees to improve quality of patient care and nurses’ work life, moving into clinical areas of their choice, and taking on leadership roles. Figure 2 outlines specific achievements of IENs in the economic, social, cultural and political domains of their nursing work life when there are deliberate efforts by the workplace to address risks of social closure and to ensure inclusive practices.

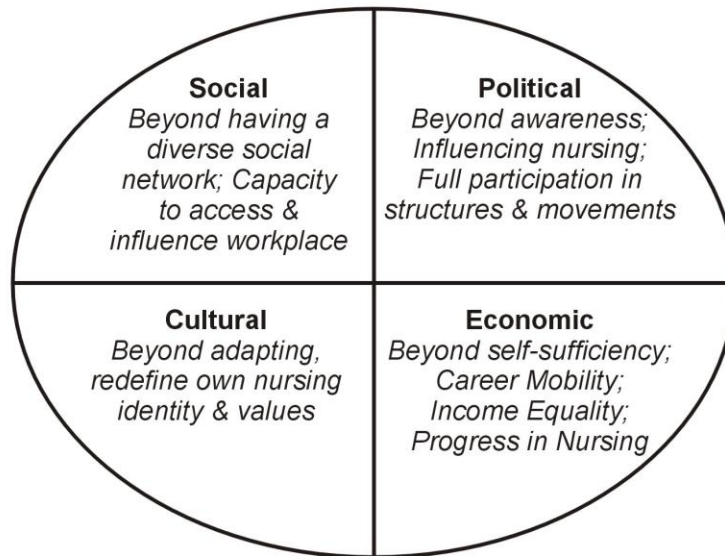


Figure 2 Domains of Workplace Integration for IENs

Adapted from CCR (1998)

While the emergent definition and the conceptual framework guided the research, the participation of IENs, employers and other stakeholders has resulted in findings and analysis which have further informed my thinking, leading to a refined framework and definition found in chapter 7.

2.4 Summary

Within the nursing literature, integration of IENs is not defined and the focus appears one-sided – that is, the emphasis is on how IENs can be made to adapt to the host country nursing and healthcare context, and the equivalent emphasis on the responsibility of workplaces or employers is absent. The notion of two-way integration is prevalent in the immigrant and

refugee studies literature, where definitions of integration include adjustments on the part of the host organization or community. Zizzo and Xu (2009) are concerned that post-hire transition programs have not been evaluated for effectiveness, and that post-adaptation research is not available to see how IENs progress in the long term. Adams and Kennedy (2006) raise the issue that despite the fact that ‘successful’ programs addressing IENs’ transition needs are being implemented, IENs’ experiences of mistreatment, discrimination and racism remain a concern. Models for organizational change recommend systematic approaches to ensure that there is broad level commitment to creating diverse, inclusive, anti-racist and enabling workplace environments that have a positive benefit on all nurses, including valuing the contributions of IENs.

Chapter 3 – Theoretical Framework

Assumptions and concepts associated with CST resonate for me and provide relevant philosophical underpinnings for this research on workplace integration of IENs in Ontario. CST, from its Marxist roots, dictates that knowledge should be used for emancipatory political aims (Campbell & Bunting, 1991). Kinchloe and McLaren (2005) explain that:

CST is concerned in particular with issues of power and justice and the ways that the economy; matters of race, class, and gender; ideologies; discourses; education; religion and other social institutions; and cultural dynamics interact to construct a social system (p. 306).

Introduction of IENs to the nursing profession and the healthcare system in Ontario has brought with it much diversity in terms of race, cultural, religion, nursing education and indigenous philosophies and practices from around the globe. While this diversity should add richness to nursing, the majority of IENs who have come to Canada over the last twenty years are racialized (CIC, 2012) and are from source countries that have long histories of colonization. An analysis of power in studies about racism in nursing identifies how organizational policies and structures embedded with dominant white norms and values have been problematic for Black (Das Gupta, 2009; Etowa, Sethi, & Thompson-Isherwood, 2009) and immigrant nurses (Hagey et al., 2001). A similar critical analysis, it seems, appears to be absent in the body of literature about IENs.

This chapter discusses an analysis of power in order to understand how organizational dynamics in workplaces can impact IENs' socioeconomic, political and cultural integration. Building on Weber's (1978) approach to power, Lukes's (2005) theory of three dimensions or faces of power is reviewed to inform the research. Lukes's theory provides insights as to how oppression and power imbalances impact not only groups such as IENs, but also the structures and systems that make up their workplace organizations. The need for a CST perspective is

justified in order to analyze IENs' workplaces and facilitate organizational transformation to promote inclusion. This type of inclusive environment would promote the desired two-way integration that is noticeably absent (UNHCR, 2005), and demonstrate leadership in facilitating organizational change that addresses power imbalances for IENs. When IENs are able to participate fully and equally, with a greater sense of belonging, acceptance and recognition, they are more likely to reach their full potential and have the will to influence their environment (Sadan, 1997; Schultz & Sankaran, 2006). Given the extensive amount of time taken up by the IENs' nursing work life, the organizational environment and context plays a crucial role in facilitating workplace integration. Drawing on the works of Weber and Lukes, the aim is to understand how power relations in the workplace organization affect IENs' full and equal participation and their integration. An organizational context grounded in CST holds much promise for IENs to achieve integration in terms of their social, political, cultural and economic domains of life in nursing.

3.1 Weber's Theories of Domination and Social Closure

Weber (1978) wrote extensively about domination as a form of power. While he talked about it emerging in diverse forms, dominance through economic power was a particular emphasis for him (Parsons, 1947). According to Weber (1978), two diametrically contrasting types of domination exist: first, domination through a constellation of interests or a position of monopoly (frequently economic) where one is in a legitimate role to impose and has "power to command" (p. 30). The second type of domination is by virtue of authority or being in a role or position, where the dominated have the "duty to obey" (p. 30). Weber (1978) describes power as being evident when one party gets their own way despite opposition. Lukes (2005) explains that

Weber's concept of power was finite, that it can only be obtained at the expense of someone else, and that it is used for the dominant individual or group's own benefit.

The concept of occupation and the types of occupational structures were the basis on which Weber (1947) discussed social stratification, including the distribution of opportunities for education for different classes. Roscigno et al. (2007) clarify that Weber highlighted social closure as "the process or processes by which individuals and collectivities maximize their advantage by restricting access or privileges to others, usually through institutional exclusion or dominant group positioning" (p. 316). Weber had conceptualized two conflicting sub-processes of social closure: exclusion by the dominant group, and in response as a form of collective resistance, usurpation by the powerless or subordinate group (Elliott & Smith, 2001). Elliott and Smith (2001) point out that the working definition of Weber's social closure in the literature has become unidirectional and narrowly focused on the top-down exclusion. They suggest that this is the case because groups with greater political, social, and often economic power are better able to restrict access to resources and opportunities - "those on the top exclude those on the bottom from full benefits (such as income and authority) of joint enterprises, thereby preserving in-group advantage" (Elliott & Smith, 2001, p. 259).

Within the context of the professions, Parkin (1979) is cited extensively for demonstrating how Weber's concept of monopoly and theory of social closure, also coined as professional closure, are exclusionary when academic or professional qualifications and credentials are imposed to limit admissible members. While IENs employed in nursing have attained registration, the "key" to social closure, this does not preclude intra profession stratification associated with gender, race, socioeconomic class, age, immigration status, or other social identities (Chua & Clegg, 1990; Macdonald, 1985).

Kanter (1977) describes the role that social closure plays in allocating workplace authority, where qualified employees from minority backgrounds are placed lower in organizational hierarchies. She explains that since senior managerial roles are less structured and more uncertain, a premium is placed on trust and that for decision makers, trust is facilitated by social homogeneity - the basis of shared understanding, solidarity and commitment (Kanter, 1977). Elliott and Smith (2001) found that dual processes of exclusion and usurpation are at work when ethnic matching of supervisors to subordinate workgroups is used as a strategy by employers to reduce perceptions of discrimination. While usurpation by frontline workers results in a positive outcome of having “one of their own” in a position of immediate authority, Elliott and Smith (2001) argue that it fulfills the exclusionary goal of senior management as the ethnic supervisor is relegated to the lower ranks and chances of upward mobility are limited.

Weber’s concept of dominance and theory of social closure have been foundational concepts for others to study and refine further. Steven Lukes’s (2005) interest in power helps further our understanding of power imbalances and resultant effects on individuals, groups and organizations.

3.2 Lukes’s Three Dimensions/Faces of Power Theory

Lukes (2005) builds on the works of Weber and other Weberian thinkers that followed in the 1960’s, such as Dahl and Bachrach and Baratz. Lukes’s three dimensions, also known as the “three faces”, of power theory, attributes the first and second dimensions of power to these theorists, while the third dimension of power is his own contribution to power analysis. Each of the three dimensions is explained next, along with some relevant applications within the context of nursing and IENs.

3.2.1 First dimension or the overt face of power.

The first dimension or overt face of power is the pluralists' perspective about the way decisions are made: "A has power over B to the extent that he can get B to do something that B would not otherwise do" (Gaventa, 1980, p. 5). In this dimension the focus is on who participates, who gains and who loses, and who prevails in decision-making (Gaventa, 1980; Lukes, 2005; Sadan, 1997). The assumption is that the decision-making process is open to everyone or virtually any organized group who cares about the issues at hand (Gaventa, 1980; Lukes, 2005; Sadan, 1997). Since the process is considered open, leaders are assumed to be speaking on behalf of a group and so non-participation or inaction is not seen as a problem, but instead is taken to reflect consensus (Gaventa, 1980; Lukes, 2005; Sadan, 1997).

With respect to marginalized groups, in this dimension, the possibility of power relations is not considered but instead non-participants are blamed or thought of as apathetic or incompetent (Gaventa, 1980; Lukes, 2005; Sadan, 1997). Strategies to correct this situation try to "educate" or change the non-participants, still with the assumption that power constraints will not pose any barriers to increased participation (Gaventa, 1980; Lukes, 2005; Sadan, 1997). An example would be when IENs are not getting involved in committees or advisory structures like the nursing council in the hospital/workplace. The leadership targets the recruitment of IENs through an awareness raising strategy, but does not anticipate the supports the nurses might require to deal with ensuing power dynamics with the majority or dominant group on the council.

3.2.2 Second dimension or the covert face of power.

The second dimension excludes certain participants and issues altogether. This face of power creates bias by establishing what is important and what is unimportant. Organizations or groups take advantage of certain kinds of conflict and actively suppress others, so that issues are

prevented from arising in the first place (Gaventa, 1980; Lukes, 2005; Sadan, 1997). The focus is not to prevail in a struggle, but to predetermine the agenda of the struggle itself (Gaventa, 1980; Lukes, 2005; Sadan, 1997). This dimension does not consider how power intervenes in the issue-raising process and what barriers might explain non-participation by marginalized groups (Gaventa, 1980; Lukes, 2005; Sadan, 1997). Gaventa (1980) explains that within this view, fear and vulnerability are the concern for marginalized groups, instead of apathy. An example of this covert face of power was implied in the 1990's case before the Ontario Human Rights Commission, which found that Black nurses at Northwestern General Hospital, some of whom may have been IENs, were actively streamed into long-term care while White nurses applying for jobs were asked for their specialty preferences (Hagey et al., 2001).

Another concept related to Lukes's (2005) covert face of power is Mann's "organizational outflanking" (Sadan, 1997, p. 46). Organizational outflanking is when the powerful exert themselves or prevent resistance through priority setting – this is achieved through the formation of alliances and networks or collective organizations (Sadan, 1997). The powerless group is "outflanked" because it does not have information about the rules of the game, the agenda, and the meaning of informal behaviour; the ignorance is more profound when they do not even identify the game itself (Sadan, 1997). Isolation or lack of information about others who share the same fate or separation from others through use of time and space allows division of groups from one another so that it is impossible to create an alliance to resist power (Sadan, 1997).

3.2.3 Third dimension or the latent face of power.

The third dimension or latent face of power developed by Lukes (2005) essentially means, "A exercises power over B by getting him to do what he does not want to do, but he also

exercises power over him by influencing, shaping or determining his very wants” (Gaventa, 1980, p. 12). In other words, the powerful group prevents the marginalized from effectively raising issues which also impacts their conception of the issues altogether (Freire, 2009; Gaventa, 1980; Lukes, 2005; Sadan, 1997). This dimension is the hardest of all to identify because people influenced by this latent power find it difficult to discover its existence (Freire, 2009; Gaventa, 1980; Lukes, 2005; Sadan, 1997).

A related analysis of latent power is Paulo Freire’s (2009) “false consciousness”. Freire (2009) describes the ability of powerful or dominant groups to identify their norms and values as the “right” ones in society and utilize their power to enforce them onto others. The impact on the powerless is such that if the dominant culture does not value the marginalized group’s characteristics or talents, belonging or being seen as part of the group becomes an impediment, with the result that group members develop inferiority, low self-esteem and self-hatred (Roberts, 1983). Aggression within the group can emerge as a result of being fearful or feeling unable to revolt against the dominant group; this leads to fear of change and the sense that the status quo is acceptable no matter how oppressive the situation is (Gaventa, 1980). Roberts (1983) discusses the domination of nursing by medicine and administration, resulting in a lack of pride in the profession through lack of involvement in professional organizations, and horizontal violence amongst nurses, as evidence of the effects of latent power.

3.3 Effects of Power

Lukes’s (2005) three dimensions, or faces of power theory, assists in the identification of the myriad ways by which oppression can be felt at the individual, group, and institutional levels,

impacting society at large. Potential effects at the level of the individual or group of the IENs and their workplace organizations are illustrated further next.

3.3.1 Experiences at level of individuals or groups of IENs.

There is a dearth of literature related to IENs and power. On the contrary, there is much literature describing the experiences of IENs going through the regulatory process to achieve registration and transitioning into the nursing workplace (Blythe, Baumann, Rheaume, & McIntosh, 2009; Charest, 1992; Ibitayo, 2010; Kawi & Xu, 2009). From the time of researching options for migrating to Canada, to navigating through these processes, there is a bombardment of messages directed at the IEN which focuses on deficits or gaps, with constant comparisons to Canadian nursing standards or “how we do things here” (Bradley & Ramji, 2012). The literature further problematizes the IEN through several themes that imply what is required in order to be successful in the Canadian healthcare environment. The oppression experienced by IENs can be amplified by considering three additional factors: the influence of liberal ideology in nursing in the West; the relevance of IENs’ multiple social identities, including gender and race; and the residual effects of colonization on IENs’ cultures.

3.3.1.1 Influence of liberal ideology.

Browne (2001) states that because of the prevalence of liberal ideologies in nursing in the West, subjective and individualistic viewpoints do not consider broader structural oppression, nor do they advocate for change. It can be argued that IENs are subjected to this individualistic ideology whereby structural conditions are a given, and the only option is to maneuver within them (Browne, 2001). The responsibility is on the IENs to adapt and cope with the situation, to take greater control of their lives despite social and/or economic inequities (Browne, 2001; Culley, 1996).

3.3.1.2 Role of multiple social identities.

The majority of IENs are racialized women, with the highest immigration noted from the Philippines and India (CIC, 2012). The lack of recognition that IENs have multiple social identities (gender, race, language, faith, sexual orientation, etc.), which impact them further in terms of barriers and oppression, is problematic (Boutain, 1999; Hagey et al., 2001; Kersten, 2000). In studies on racism, racialized nurses felt “less than” or “othered”; they were subordinated, disadvantaged, restricted, silenced and not told about opportunities (Das Gupta, 2009, Etowa et al., 2009; Hagey et al., 2001). In Hagey et al.’s (2001) research, immigrant nurses experienced chaos, felt excluded, and had to make extraordinary efforts to overcome barriers; there were persistent issues about who gets what and who is automatically overlooked or denigrated.

3.3.1.3 Effects of colonization.

Given the long histories of colonization in many of the countries of origin of IENs, Gaventa’s (1980) views about the effects of the colonizing process are relevant. The colonizer prevails and creates dependencies through the establishment of various institutions such as the education and healthcare systems in the colony (Gaventa, 1980). The colonized begin to see their own values and norms as inferior and internalize the colonizer’s norms, to the extent that there is reshaping and embedment of these wants, values, roles and beliefs in the colony’s institutions and organizations (Gaventa, 1980). Gaventa (1980) further challenges us to think about whether such colonizing processes exist within our current context. An example could relate to how western models have influenced nursing education and practice in the countries that IENs originate from, and the extent to which traditional approaches and indigenous practices to caring and healing may be abandoned or seen as inferior. Choy (2003) supports this analysis in her

work on the role of US colonialism in the early twentieth century in the Philippines through the creation of an Americanized hospital training system for Filipino nurses. Ways in which dominant ideas get embedded in organizational systems and structures is discussed next.

3.3.2 Effects of power at level of the organization.

The experiences of discrimination and inequitable practices of individuals/groups from a minority or ‘different’ background, such as the case for IENs, are usually part of an overall encounter with an inflexible, exclusive organization (Minors, Mukherjee & Posen, 1995). Everyday common institutional policies and practices are frozen in the ideas, beliefs and assumptions of the dominant group and have an adverse impact on the less powerful groups (Boutain, 1999; Hagey et al., 2001; Minors et al., 1995).

Minors et al. (1995) developed the three “I’s” model (Ideas, Institutions, Individuals), to illustrate how ideas prevalent in society (i.e. the dominant views), reinforce and legitimize institutional policies and practices as well as individual behaviours. The three “I’s” interact with each other and perpetuate the oppression in the organization (Minors et al., 1995). For example, if there is a prevailing idea that the way IENs from the Philippines or India speak is hard to understand because their communication styles and accents are so different from the way “Canadians” speak, then an institutional requirement that nurses be able to communicate effectively may be interpreted to mean the ability to communicate only in a particular way (Minors et al., 1995). At the individual level, the decision maker is so accustomed to only the dominant “Canadian” way of communicating, that those who are different are adversely affected; the requirement of effective communication will thus unconsciously acquire a specific meaning of what the “norm” is, to the disadvantage of any IEN who does not fit that norm (Minors et al., 1995). Minors et al. (1995) further argue that all of the characteristics of an organization, from

its structure, decision-making processes, communication vehicles, and even to its mission, are based on assumptions about individuals and groups. Although organizations are not homogenous, and typically there is variation between departments, with increasing diversity within the staff pool and client population, challenging of these assumptions and establishing new ones is necessary to promote inclusive practices (Minors et al., 1995).

3.4 Examining and Addressing Power Relations at the Organizational Level

Gaventa (1980) researched powerlessness based on Lukes's (2005) three dimensions or faces of power. He concluded that the powerless have to overcome the latent (third dimension) and covert (second dimension) faces of power first, before being able to withstand/tackle the overt (first dimension). Building on Paulo Freire's (2009) Theory of Revolutionary Action, Gaventa (1980) also argues that a challenge or "rebellion" can occur only if there is a shift in power relations and either "A loses power or B gains power" (p.23).

Starting with the cumulative effects of oppressive acts that lead to a 'revolutionary moment', a phased approach is outlined by Freire (2009): with the leadership from within, the powerless group has to go through a process of issue and action formulation (critical reflection), and then carry out a process of mobilizing and acting upon the issues (revolutionary praxis). This is promoted as an effective strategy for organizing and forming alliances among the powerless, so that they are then able to mount resistance, with the aim of engaging in dialogue about change within the dominant group (Freire, 2009; Gaventa, 1980; Kendall, 1992; Sadan, 1997). This approach is in line with emancipatory nursing practice that focuses on how people can change their situation rather than the traditional aim of helping them simply adapt and cope with their oppression (Browne, 2000/2001; Kendall, 1992). However, it appears to be one-sided, as the

burden of responsibility for initiating change is placed squarely on the shoulders of the powerless individuals/group. This approach places no responsibility nor sets any expectations for the dominant structures to change. A CST perspective ensures that organizations are taking on their share of responsibility to shift power and dismantle barriers, by questioning and analyzing all structures and practices. It is critical to determine if organizational practices automatically give privilege and normality to the dominant group, and only by default to the “other” groups (Hagey et al., 2001).

3.5 Critical Social Theory and Organizational Analysis

A CST perspective involves a commitment to open, non-authoritarian communication with the aim of hearing diverse and under-represented voices (Weaver & Olson, 2006). Along with this open dialogue, there is persistent questioning and critiquing of the organizational conditions, in order to understand how they might be affecting certain groups adversely (Kendall, 1992; Nussbaum, 2000). Organizational mechanisms that allow participation by all groups, especially the marginalized groups, enable active engagement with each other to develop political consciousness of their own situation, and of broader inequalities affecting others (Freire, 2009; Gaventa, 1980; Kendall, 1992; Sadan, 1997).

Problems facing racialized and ethnic groups are unfortunately reduced to cultural insensitivity on part of the healthcare organization (Culley, 1996). The easy, quick fix is appropriate professional “education” to understand and respect cultures different from their own (Culley, 1996; Minors et al., 1995). The pluralists’ assessment of the problem is simply a mismatch of minority and majority cultures; the importance of power is played down and the inequality and racism embedded in the institutional practices is ignored (Culley, 1996; Minors et

al., 1995). Since CST's goal is to counter oppression and redistribute power and resources, strategies for planning and taking action towards change are an imperative (Maguire, 1987). Using a gender-based analysis, Nussbaum (2005) stresses the need for CST inquiry within the organizational context to examine power relations.

Nussbaum (2005)'s framework of critical questions (see Appendix II) relates to issues of resources, hierarchy, and policies within organizations, and stimulates thinking from a CST perspective regardless of the social identity and oppression. For instance, resources are not just economic, but also personal and social and can influence interactions and outcomes, including information, control over meanings, and access to networks (Nussbaum, 2005). Since needs for resources vary among people, at different times and according to capabilities, based on Nussbaum's framework, one question is whether the employer is considerate of the need for differential supports for diverse IENs. Nussbaum (2005) also states that formal and informal hierarchies exist in every social entity. However, they may not be readily understood by newcomers or "outsiders". Critical questions would reveal decision-making mechanisms for how "rules" in the form of policies, written and unwritten, have come about and how they affect different groups (Nussbaum, 2005). In the context of integration of IENs, critical inquiry can facilitate the dismantling of barriers that lead to exclusion in all domains: social, cultural, political and economic (Omidvar & Richmond, 2003). Frameworks for assessing organizational processes, developing plans for change, and their relevance to IEN integration, are discussed next.

3.6 Linking Power and Workplace Integration of IENs

Lukes's (2005) three dimensions or faces of power theory provides important insights on how power imbalances can affect IENs adversely at the individual or group level, as well as through workplace organizational systems which may be entrenched in norms that do not value difference. The first dimension or overt face of power highlights assumptions inherent in democratic, pluralist approaches that are "open" but insensitive to power imbalances that could prevent individual/groups of IENs in participating in organizational processes. The blaming behaviour and the misinterpreting of non-participation as incompetence can further exacerbate the feelings of powerless for IENs.

The second dimension or covert power points to how issues important to IENs could be actively left "off the agenda" in the workplace. The need for differential supports that recognize particular needs of IENs could be ignored. Being excluded from opportunities for professional development, leadership roles or other forms of job enhancement, along with the separation from other IENs with a similar plight (e.g. being the only IEN on the unit or shift), could reinforce the sense of devaluation, fear, vulnerability and isolation.

The most insidious type of power dynamic was highlighted in Lukes's (2005) third dimension or the latent face of power. Its powerful influence can make organizational systems and structures work in ways that may not be advantageous to IENs (because of their "difference") and may even reinforce a sense of inferiority. While IENs could be aware of how latent power is affecting them, repeated experiences of overt and covert faces of power may result in the perception that the price of resisting change is too high. Broader influences from oppressive histories of colonization and prevalence of liberal ideological values of individualism may add to their sense of defeat, impacting their abilities to effectively integrate in the social,

cultural, political and economic domains of their nursing work life. Minors et al.'s (1995) The Three "I's" Model has been adapted in Figure 3 to illustrate the resultant effects of power relations in IENs' workplace organizations.

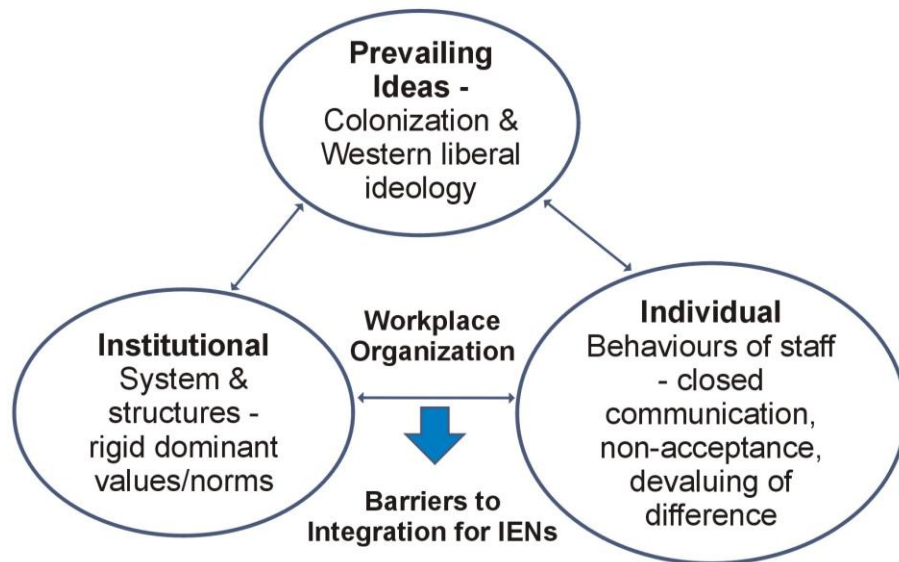


Figure 3 Effects of Power and The Three "I's" Model

(adapted from Minors et al., 1995)

The notion of integration as a two-way process and outcome, in social, cultural, economic and political domains, provides a healthy vision for IENs' workplace organizations to consider. This vision developed within the immigrant and refugee studies literature is synchronous with critical social theorists' plea for nursing to critically examine sociopolitical structures and advocate for changes that shift the power and lead to equitable outcomes for marginalized groups.

CST inquiry is also justified by Adams and Kennedy's (2006) observation that healthcare organizations have been lagging behind when it comes to taking a coordinated, organization-wide approach to supporting the integration of IENs. Using a CST perspective, organizational

and nursing leaders can plan a deliberate strategy for change. Models for organizational change, including those that pay specific attention to the social identity of race, can serve as frameworks to promote inclusive practices. When the organizational environment is inclusive, there is greater participation by IENs in all aspects, leading to a sense of belonging, feelings of acceptance, recognition and value. These are all pre-requisites for IENs to reach their full potential in terms of their integration, as well as their capacity to influence the broader nursing and healthcare community.

3.7 Summary

Aside from the lack of definition of workplace integration of IENs, views about effects of power and powerlessness of IENs in the workplace are also under-represented in the literature. The CST lens to critique organizational practices was utilized for continual dialogue and the creation of new and shared meanings about what integration of IENs is and can or should be. Bormann and Woods (1999) submit that organizations could recruit internationally educated professionals and be very diverse, but if deliberate, systematic strategies promoting inclusion are not in place, then the organization is continuing to acknowledge the dominant group culture and working towards assimilation instead. Maguire (1987) says that CST is concerned with countering oppression and redistributing power and resources, and that within this paradigm, research becomes a means for taking action and a theory for explaining how things could be.

Based on a CST perspective, a qualitative case study methodology has been selected for carrying out this research on workplace integration of IENs and is the focus for the next chapter.

Chapter 4 - Research Methodology

The overall design for this research was a qualitative case study methodology informed by CST. This chapter provides details of the research design, including data collection and methods of analysis, along with ethical considerations.

4.1 Research Design

A qualitative research methodology was selected because the concept of workplace integration of IENs is complex and has to be explored in depth within its natural context, with voices of IENs and other stakeholders at the centre (Creswell, 2013). Given their diverse backgrounds and experiences, the IENs and other stakeholders participating in this research have many valuable perspectives, and all themes are reported with supporting quotes as evidence. Qualitative research allows close proximity to the participants so that my interpretation of the findings emerges in conjunction with and/or shaped by the interpretations of participants. The CST perspective that guides this study of workplace integration of IENs is well-aligned with qualitative research tradition.

4.1.1 The single instrumental case study approach.

The specific methodology for this exploratory research was an instrumental case study approach focused on a single organizational site where IENs are employed (see Figure 4). As described by Stake (1995), an instrumental case study is where the case organization facilitates the understanding of something else or a phenomenon of interest. This approach to research workplace integration of IENs is justifiable for several reasons. IENs' workplace integration experiences take place within the context of nursing roles they have had since obtaining registration (licensure) in Ontario. The inseparability of the phenomenon of IENs' workplace

integration from its real-life organizational context provides rationale from a CST (Creswell, 2013) and methodological perspective (Stake, 1995). The intent in this research is to understand the phenomenon of workplace integration of IENs and to use an employer organization as a real-life illustration. As an instrumental case, the selected organization was critically examined for how commitment to integration of IENs unfolds through deliberate initiatives and how it manifests in various forms of policies and practices (Stake, 1995). An in depth exploration of workplace integration required gathering and convergence of data from multiple sources, another hallmark of case study research (Stake, 1995). Finally, Freeman et al.'s (2012) integrative review on case study approaches for investigating nurse migration, found that primary research using this methodology was lacking. They argued in favour of research from this tradition in order to have a more in depth understanding of workplace integration of IENs and related policy and program implications.

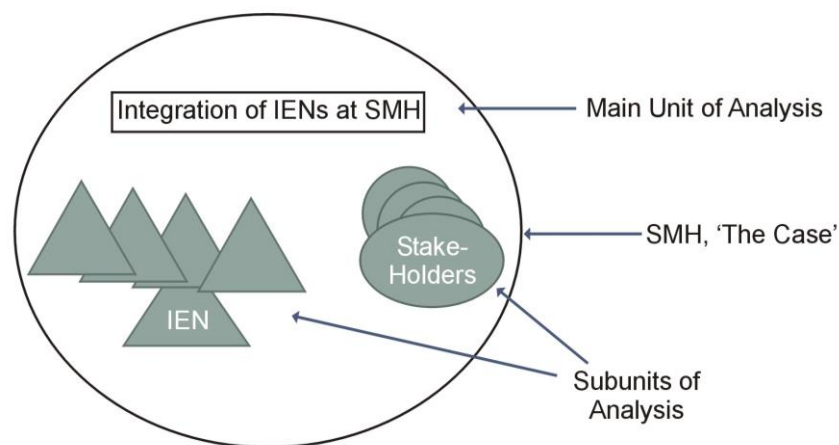


Figure 4 An exploratory, single, instrumental case study design

This qualitative single case study allowed me to look at the case organization more holistically, as well as deepen my understanding about the individual groups of sub-units i.e. IENs, peers/mentors, managers/directors and senior managers. A common problem in qualitative case study is that analysis is limited to or carried out at the sub-case level; that is, at the level of the perspectives of IENs versus non-IEN participants (Baxter & Jack, 2008). Baxter and Jack (2008) caution that the analysis has to go back to the global issue – in this case, the issue of workplace integration of IENs within the organizational context. In an attempt to understand the overall case, data from all sources are converged instead of treating and reporting each data source independently (Baxter & Jack, 2008). The purpose of the single instrumental case is not to generalize beyond the organization but to understand its complexities (Creswell, 2013). The learning derived from this single case study site is a foundational work and may give rise to a future multi-site research study.

4.2 Case Selection

Given that the objective of this study was to broaden our understanding of IENs' workplace integration, a representative case or a typical, average case organization was not going to be the richest source of understanding (Flyvbjerg, 2006). An active case would be more appropriate for the best learning to come across - an organization which is especially good in a similar sense to what Adams and Kennedy (2006) describe as a positive practice environment for IENs - one where the priority of IEN integration is embedded in all major organizational functions, and where the commitment is visible throughout. With a history of relevant initiatives, St. Michael's Hospital in Toronto was selected as such a setting.

4.2.1 Context of St. Michael's Hospital, Toronto.

St. Michael's Hospital (SMH) is a tertiary care facility with 467 acute adult inpatient beds, located in downtown Toronto (St. Michael's Hospital, 2015). The hospital serves a diverse population that includes the extremes of some of the most affluent Torontonians along the Harbourfront, as well as the most underprivileged and marginalized of the inner city neighborhoods and the Lesbian, Gay, Bisexual, Transgendered and Queer (LGBTQ) communities. With its total workforce of 5741 employees, almost 30%, or 1691, are nurses. In addition to clinical expertise in critical care and trauma, heart disease, neurosurgery, diabetes, cancer care, obstetrics, care of the homeless and global health, the hospital is recognized for its related programs of research and for education of health care professionals from several academic disciplines. The significant proportion of patients from outside of its catchment area is explained because of the ethnicity and cultural sensitivity of SMH's physicians and staff (St. Michael's Hospital, 2010).

With over 120 years of history, SMH has its roots as a Catholic hospital founded by the Sisters of St. Joseph. It has stayed true to its original mission and values by responding to the needs of the sick and poor in the south end of Toronto. This commitment became even more pronounced seventeen years ago when the closure of The Wellesley Hospital was announced by the Health Services Restructuring Commission in 1998 (Talaga, 2008). As a result of taking over many of The Wellesley's programs, especially those for the urban poor and AIDS patients, SMH's focus on inner city health became stronger (Monsebraaten, 2013). SMH implemented various strategies to get to know its diverse communities, all their differences and needs, and to involve them in advising on its programs and services (St. Michael's Hospital, 2010).

In 1998, SMH's board of directors approved a *Statement of Affirmation Regarding Accessible, Welcoming, & Equitable Health Care for All*, and a Centre for Research on Inner City Health was established (St. Michael's Hospital, 2010). Staff and management have collaborated in several community initiatives which have had emphases on social determinants of health and issues of equity and access. In its first *Health Equity Report* to the Toronto Central Local Health Integration Network (St. Michael's Hospital, 2009), specific gaps and challenges are acknowledged. However, SMH iterates health equity as a lens for planning and implementation processes across the organization. Over the years, specific initiatives relating to inequities experienced by new immigrants who are internationally educated professionals, both within SMH and at the broader system levels, have been undertaken. Following is a list of examples relevant to this study:

- Anti-racism Project (1995-1996, with The Wellesley Hospital); four areas of focus: (1) Language and Communications; (2) Attitudes and Behaviours; (3) Cultural Awareness; and (4) Institutional or Systemic Barriers (St. Michael's Hospital, 2010).
- Founding partner of CARE Centre for Internationally Educated Nurses (1999); development and ongoing involvement in governance of this new organization, including provision of bursaries and placements for observational job shadowing for IENs working on their registration process (St. Michael's Hospital, 2010).
- Hospital Mentors for Foreign Trained Professionals Project (2002-2003); new immigrants from the community were matched as mentees with SMH staff /managers as mentors (Wilson, 2009).

- Career Bridge (2004); an internship program established at SMH to mentor and reduce employment barriers for internationally trained professionals (St. Michael's Hospital, 2010).
- Strategic review and planning process led by the Chief Nursing Executive, SMH (2007); goal of recruiting and retaining top talent in nursing outlined a three-pronged approach at SMH: (1) Establishing a strategic focus on recruitment of IENs; (2) Leveraging existing corporate initiatives and building on successes; (3) Developing evidence-based integration strategies (Ferris, 2012).
- Savings created from participation in the province's New Graduate Guarantee initiative allowed SMH to re-invest in nursing, and specifically in the recruitment and orientation support of IENs (Ferris, 2012).
- Strategic plan renewal, SMH (2009); the following was adopted as one its corporate level strategic directions: "To invest in programs aimed at nurturing international/foreign trained professionals and providers as key to ensuring supply of our health care workforce" (St. Michael's Hospital, 2009, p. 3).
- Building Employer Capacity for Effective Integration & Retention of Internationally Educated Professionals (IEPs), (2009-2012); project funded by Ministry of Citizenship & Immigration to build SMH's capacity. Project elements included: customized orientation and support for IEPs (including IENs) employed at SMH, mentoring and educational workshops for IEPs and managers (Wilson, 2009).

For the above and other related efforts, SMH has received external recognition. SMH was recognized by Canada's Top 100 Employers (2008) and by the Toronto Region Immigrant Employment Council (2006, 2008) for its inclusive Human Resource (HR) practices and

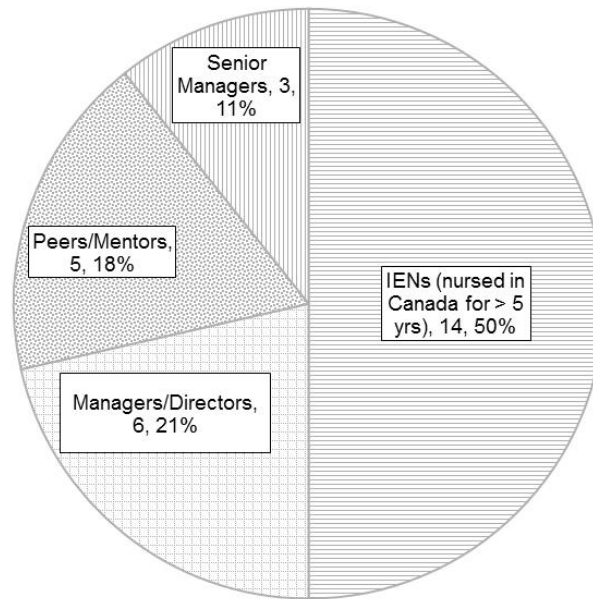
employment of new immigrants (St. Michael's Hospital, 2010). In a joint initiative of the Ontario Hospital Association and the Nursing Health Services Research Unit at McMaster University (Baumann & Idriss-Wheeler, 2012), SMH was once again highlighted as an organization with promising practices for IEN integration.

4.3 Sample

As the organizational case, SMH is an integrated system which serves as a host to many relationships or functions related to workplace integration of IENs (Stake, 2006). While the case is a single organization, it has many subunits (e.g. IENs, non-IEN nurses, educators, managers, other disciplines, etc.), who had to be sampled (Stake, 2006). Multiple information sources (Stake, 2006) were identified, as summarized in Figure 5. A purposeful sampling technique was used to select participants who met the study criteria, and because they could inform the understanding of workplace integration of IENs in this research study from specific and diverse vantage points (Creswell, 2013). The sample was fourteen IENs and fourteen other stakeholders (non-IENs) as subunits (Stake, 2006) from various vantage points within the case organization, including frontline practitioners, managers and senior administrators. The sample was also diverse with respect to age range, gender, ethno racial background, country of origin and nursing education, family and immigration status, and number of years and types of nursing or other professional work experiences. The breakdown of the twenty-eight participants or sub-units of analysis is displayed in Figure 5.

In order to understand how workplace integration is conceptualized beyond the earlier adaptation phase, IENs in the sample had to have worked in Ontario for at least five years (Neiterman & Bourgeault, 2015; Yi & Jeweski, 2000) and be diverse in their backgrounds in

terms of their country of origin. Perspectives from different levels of the case organization were provided by the non-IEN stakeholders in the sample: three nurse peers, two clinical educators (mentors), six managers (including nurse managers) and directors, and three members of the senior management team.



To focus on 'integration' and not transition, only IENs who had worked in Canada for > 5 years were included; Peers were nurses educated in Canada.

Clinical Areas Represented: Mental Health, Medical, Post-Anaesthetic Recovery, Surgical, Cardiology, Orthopedic, ENT, Neurology, Critical Care, Hemodialysis, Emergency Room

Other Areas: Inner City Health Program, Human Resources, Professional Practice, Executive Team

Figure 5 Sub-Units of Analysis (n=28)

Stake (1995) states that data from a sample of more than ten for each subgroup is unmanageable and unnecessary, while less than four may not be enough, especially when there are no pre-existing theories about the concept being studied. The sample size exceeded what Stake recommends, primarily to make provisions for attrition or incomplete interview data sets as well as to ensure a comprehensive description of the case/organization and data saturation. For

the IEN sub-unit category, data saturation was achieved with the total number of individuals being fourteen. Although the number of the sub-units in the remaining categories (i.e. peers/mentors, managers/directors, senior managers) was small, data saturation was achieved when the sub-units were combined together.

4.4 Recruitment

Purposeful sampling was the overall strategy used to select the sample for this research. According to Patton (1990), purposeful sampling is when the researcher uses her/his judgment based on the specific objectives of the research. Based on my research objectives, I decided which sub-units were best suited to provide a range of perspectives about workplace integration of IENs at the case organization. Variation in the sample was given emphasis in order to maximize learning (Creswell, 2013).

To begin recruiting IENs and frontline nurses for the sample, I arranged to be placed on the agendas of the Nursing Advisory Council, meeting of the Nurse Educators and unit level teams. The purpose and approach to the research process was outlined, along with my contact information as the researcher. A recruitment information letter as shown in Appendix III and a poster (Appendix IV), were handed out at these meetings. An email (see Appendix V) was sent to key individuals in specific roles at other levels of the organization.

A snowball technique was also utilized. Snowball technique refers to when research participants are asked to assist in identifying other potential participants who meet the sample criteria and are information-rich (Miles & Huberman, 2014; Creswell, 2013). Information-rich individuals are those from whom the researcher is likely to learn a lot about the topic or phenomenon of primary interest (Patton, 1990). IEN participants were asked to suggest names

and facilitate referrals to individuals who met the sample criteria (Creswell, 2013). Nurse Managers, Educators, Directors and peers were also identified using the snowball technique.

4.5 Data Collection

There were four main forms of data collection: semi-structured interviews; socio-demographic survey; review of documents; and focus groups with IENs and other stakeholders. Each stage of interviews or review of documents informed the subsequent steps.

4.5.1 Semi-structured interviews.

A total of twenty-eight interviews were carried out, half of which were with IENs, and the rest with individuals from various areas and levels of the organization. An interview guide (Appendix VI) based on the conceptual framework that anchored the research, was utilized for each interview (Baxter & Jack, 2008; Miles & Huberman, 2014; Stake, 1995). Essentially the questions were sub-questions of the research questions (Creswell, 2013) and were grouped in three broad areas: (i) what is meant by workplace integration of IENs; (ii) how has the workplace environment adjusted; and (iii) organizational factors that facilitate or inhibit workplace integration. Interviewees also shared information which was of interest or relevance to them but fell outside of these areas. This has added to the richness of data gathered and analyzed.

The interview guide was pilot tested with two IEN colleagues and refined as appropriate (Creswell, 2013). As information was gathered and preliminary analysis emerged, interview questions were modified (Miles, Huberman & Saldaña, 2014; Stake, 1995). The duration of the interviews ranged from forty-five to seventy-five minutes. The interviews were held in a mutually agreed upon location, in a quiet and private space. To ensure privacy and confidentiality, an offsite location at CARE Centre for IENs, accessible by public transit, was

offered but not accepted by any of the interviewees. One participant preferred to meet in a public space closer to her place of residence, and the remaining participants were all interviewed onsite at the case organization. For participants who wished to remain onsite, arrangements for a meeting room away from the clinical areas were made; others preferred to have the meeting in their respective designated offices.

All interviews were transcribed verbatim by a professional transcription service within three to seven days. Transcriptions were reviewed within three to seven days of each interview and an overall summary of the main points was developed using the contact summary form (Appendix VII) and field notes from the time of the interview. Important guides or queries for the subsequent encounter or interview were flagged and preliminary coding of themes in a column served as part of the broader inductive analytic process at the later stage.

4.5.2 Socio-demographic survey.

To develop a profile of participants who were interviewed, a brief five-minute demographic questionnaire (Appendix VIII) was self-administered at the start of each interview to all of the participants, with more additional details collected from IENs (see Figure 6). The demographic data was analyzed using Microsoft Excel to produce the participant profile.

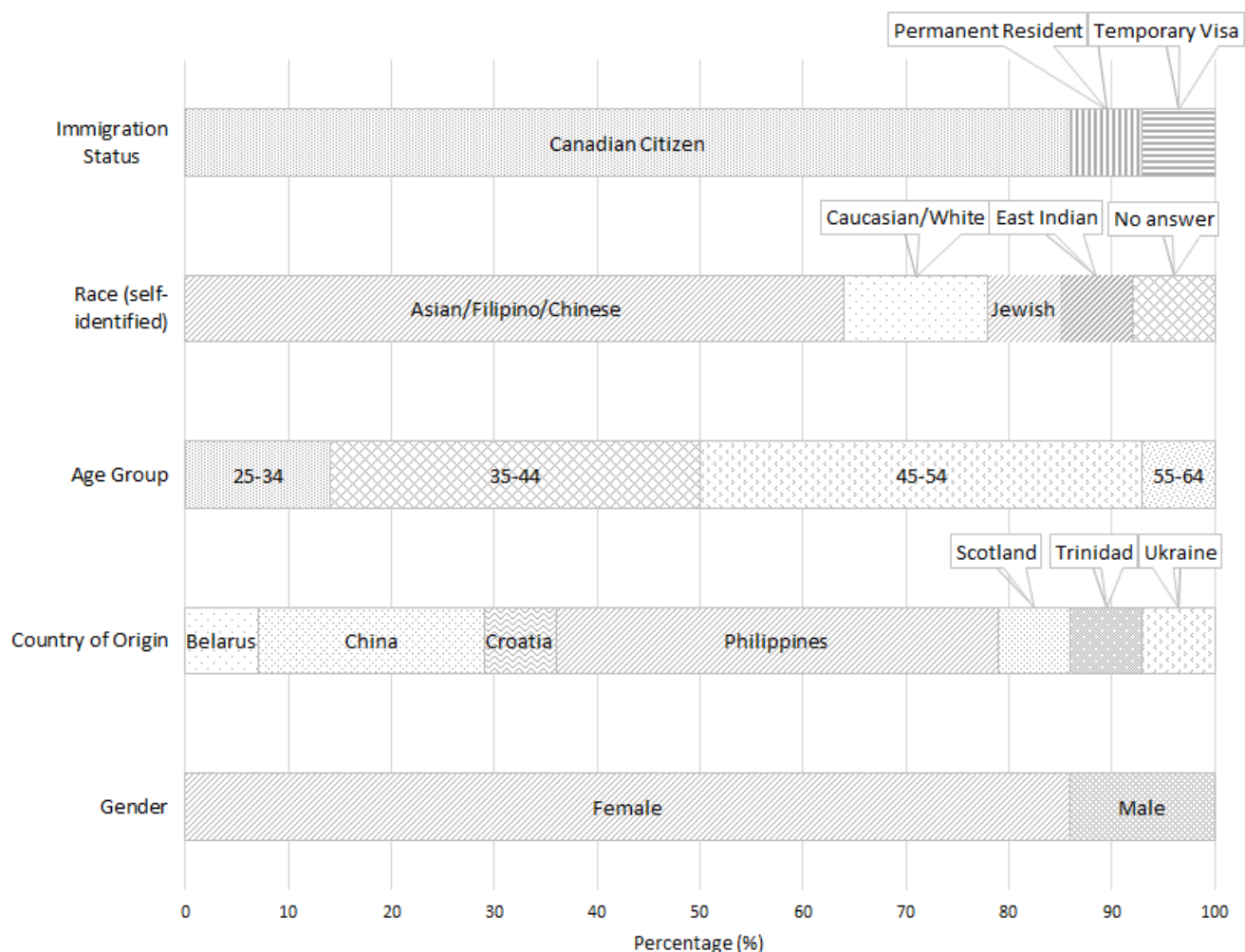


Figure 6 Demographic Profile of IEN Participants (n=14)

The majority of the IENs were female (86%) and in the 35 to 54-year age group (79%). Most of the IENs were Canadian citizens (86%) and had originated from seven countries: Philippines (43%), China (22%), Belarus (7%), Croatia (7%), Scotland (7%), Trinidad and Tobago (7%) and the Ukraine (7%). All of the IEN participants were practicing in the registered nurses (RN) category of nursing. The case organization does not recruit registered practical nurses (RPNs) for its nursing staff teams. On average, IENs had 5.6 years of nursing experience prior to coming to Canada, with a total average of having worked as a nurse for 16.5 years. The

sampling criteria for the IENs had been set at a minimum of 5 years of Canadian nursing experience. The IENs interviewed had an average of 10.9 years as a nurse in Canada, with most of these (9.7 years) right at SMH. The non-IENs who participated had worked in healthcare for an average of 25.3 years; 16.7 years of that time had been working at SMH. The IENs and other nurse participants worked in various clinical areas, including: Mental Health, Medical, Post-Anaesthetic Recovery, Surgical, Cardiology, Orthopedic, ENT, Neurology, Critical Care, Hemodialysis and Emergency Room.

4.5.3 Documents review.

Key documents, both formal and informal, were reviewed to understand the organization's context as well as to assess alignment between what is on paper and how interviewees perceive or talk about organizational practices and behaviour. Data were collected through reviewing twenty to twenty-five organizational documents. These included annual reports (for the overall public and specific ones on health equity initiatives for the Local Integrated Health Network), strategic plans (corporate and Professional Practice), IEP project reports and presentations, IEP survey results, specific policies and procedures (e.g. Nursing Performance Appraisal process, Workplace Harassment, Managing Violence in the Workplace, Dress and Department) and media articles. Most of the documents were available through the case organization's website; additional documents of interest were identified at various steps in the process through discussions with the participants (Crowe et al., 2011; Stake, 1995). When reviewing the documents, notes were taken of key ideas of relevance to this study. These notes formed the basis of analysis for this aspect of the research.

4.5.4 Focus groups.

Following a preliminary analysis of the interview transcripts and documents, participants were invited back to participate in focus group discussions. Information (Appendix IX) about participating in the focus group was provided at the time of their individual interview, with subsequent follow up to confirm their involvement. Five focus group discussions were held over a two-week time frame: two with the IENs, one with peers/mentors, one with managers/directors and one with senior managers. A total of thirteen or 46% of those who had been interviewed, participated in the focus groups. The purpose of the focus group discussions was multifold. A presentation of the key findings preceded the discussion, and in addition to collecting more data, the focus groups also served as a form of member checking and provided the participants to help in the shaping and reshaping of the study findings and its recommendations. Appendix X has the focus group discussion guide.

4.6 Data Analysis

At a preliminary level, data analysis occurred simultaneously with data collection; it was inductive and iterative. The CST perspective that underpins this research design informed the data analysis. This philosophical orientation is compatible with the view that qualitative case study approaches are based on the belief that knowledge is constructed rather than discovered (Stake, 1995). Qualitative data analysis software, NVivo 10, was utilized to make the organizing, re-organizing and retrieval of data more efficient, especially for purposes of within sub-unit and across sub-unit analyses (Creswell, 2013). For the descriptive analysis, inductive coding was utilized as the primary technique.

4.6.1 Inductive coding.

Inductive coding was one of the initial stages of data analysis. I listened to each audio recording of each interview and read the transcription to ensure accuracy and to immerse myself sufficiently for coding purposes. Inductive coding of the data from the interviews and document sources did not start with a pre-established list of codes but instead the codes emerged from the data. Specific steps included: (i) reading the summary forms and making margin notes; (ii) re-reading the transcripts, making margin notes and reviewing the margin notes to identify/label emerging codes; (iii) re-reading the transcripts and highlighting according to these codes; (iv) bringing all data coded the same together to determine specific themes under each code; (v) reviewing the themes and re-assessing the coded data to ensure they all belong together, and (vi) naming and defining the themes (Braun & Clarke, 2006). Analyzing the perspectives of an individual IEN (within subcase analysis) and then analysis of the IENs in the sample (between sub-unit analysis), followed by analysis of the IENs with the non-IEN stakeholders (across sub-unit analysis), all provided important ways of understanding the overall case organization (Baxter & Jack, 2008). Beyond description, data was explained by using the analytical filters embedded in the conceptual framework.

4.6.2 Analytical filters.

After the inductive coding phase, codes and themes were reviewed against the conceptual framework. Miles and Huberman (1994) suggest that while starting with an inductive approach may be appropriate, “not to ‘lead’ with your conceptual strength can be simply self-defeating” (p. 17). Displays of data in the form of concept maps, graphs, charts, diagrams or matrices are all helpful in progressing from describing to explaining data (Miles & Huberman, 2014).

The specific components of the conceptual framework formed some of the major themes in the data and served as analytical filters (Baxter & Jack, 2008). The conceptual framework and the a priori codes embedded within it served as a guide for the data analysis; they did not impose or constrain the analysis process. Analyzing against the conceptual framework also helped converge all of the data, including those from interviews, focus groups, document review and demographic survey. This mitigates the risk of analysis staying at the data source or sub-unit level (e.g. what the IENs' perspectives were versus peers) and not brought to the level of the global issue being studied – that is, workplace integration (Baxter & Jack, 2008).

4.7 Methodological Rigour

Criteria for achieving methodological rigour as recommended by Lincoln and Guba (1985) were applied and documented. Four criteria selected for this research were: credibility, transferability, confirmability and reflexivity. Each criterion with corresponding techniques is described next.

4.7.1 Credibility.

Credibility refers to believability of the results of the study or the extent to which the researcher is truly conveying the participants' experiences and perspectives (Carnevale, 2002). Three techniques for ensuring credibility used in this research were member checking, triangulation and peer debriefing.

4.7.1.1 Member checking.

Each interview transcription was emailed to the respective participant so that s/he had an opportunity to identify any errors or omissions, as well as provide any further reflections on the topics discussed.

Once the data collection was complete, another form of member checking was through focus group discussions with each of the subgroups of participants – the IENs, the non-IEN nursing peers, nurse managers/directors and senior management. The focus groups served as an additional opportunity to identify any misinterpretations or omissions on my part as the researcher. For example, the concept of equity was amplified by the focus group participants.

4.7.1.2 Triangulation.

Triangulation was conducted first through use of corroborative evidence from the semi-structured interviews, document review and focus groups, to shed light on a theme or perspective (Creswell, 2013). Aside from data triangulation from interviews with sub-units with different vantage points, focus group discussions and organizational documents were important sources of data, clarifying given themes. In addition, triangulation (Shih, 1998) occurred at the IEN or each of the sub-unit level, as well as between IENs and across sub-units of the peers/mentors, managers/directors and senior managers. In the context of this qualitative case study approach, the purpose of multiple triangulations was to achieve a more complete data set (Shih, 1998) and therefore a more complete portrayal of the phenomenon of workplace integration of IENs.

4.7.1.3 Peer debriefing.

Regular debriefings were also carried out with my thesis supervisor. Contact summary forms, journal notes and memos were the source of key issues or patterns and comparisons for discussion at the debriefings.

4.7.2 Transferability.

Transferability refers to the degree to which the findings reflect the experiences of individuals in other similar settings or contexts (Carnevale, 2002). In this study, the aim has been to provide a thick description so that the reader who is interested can reach a conclusion

about transferability to another similar situation (Lincoln & Guba, 1985). Case study methodology produces robust data sets from multiple sources (Stake, 1995). Based on the claim that truth is relative and that it is dependent on one's perspective, as the researcher, I have attempted to provide my readers with detailed information, including direct quotes from the data so they may interpret for themselves (Stake, 1995). The "thick description" that emerges from this methodology emphasizes interpretations of sub-units who were interviewed in the study as the most knowledgeable about the case organization (Stake, 1995).

4.7.3 Confirmability.

Confirmability is the assurance that data was collected and analyzed in a way that minimizes any distortion of the participants' views (Carnevale, 2002). An audit trail was used as the technique to address confirmability. A systematic and detailed record of the data collection and analysis process was maintained so that a third party or reader can confirm that they would arrive at the same conclusions. Specifically, four categories of records were kept (Lincoln & Guba, 1985): (i) raw data (e.g. transcription of interviews and focus groups); (ii) data reduction and analysis products (e.g. contact summary forms, excel document with demographic data; (iii) process notes (e.g. journal and memos and notes from debriefings with supervisor and thesis committee); and (iv) data reconstruction and synthesis products (e.g. analytical matrices, table or flow charts and drafts of thesis).

A final technique that applies to ensuring credibility, transferability and confirmability is the reflexive journal, used to record a variety of information about the self and the method (Lincoln & Guba, 1985).

4.7.4 Reflexivity.

Journaling (through memos to myself as the researcher) has been the main vehicle to being reflexive. The journal was to record my thoughts, feelings, observations and reflections. As ideas or codes become apparent to me throughout the study process, they were noted in emails to myself. When conceptual patterns or comparisons began to make sense, I emailed memos to myself, and at strategic points discussed with my thesis supervisor and the thesis committee. These were mostly conceptual in nature when the bringing together of different data began to make sense. The journal and memos were kept close at hand during later phases of the analytical process.

My various social identities and daily proximity to issues of IEN integration in my role at CARE Centre for IENs are likely to have impacted my interactions with participants. Sutherns, Bourgeault and James (2013) assert that the ability of the researcher to relate to the embodied experience of the participants should be seen as an asset, as it affects the depth of understanding of the issues, facilitates all phases of the research process including data collection, and may even yield richer results. At the same time, given my role and position, self-discipline and self-awareness has been critical in order not to make assumptions or draw inappropriate conclusions (Sutherns et al., 2013). Regular reflection was important so that I was listening carefully and fully throughout, and that I analyzed critically.

4.8 Ethical Considerations

Research ethics approval was obtained from the University of Ottawa (Appendix XI & XII) and from the study site, SMH's Research Ethics Board (REBs) (Appendices XIII & XIV). The ethical protocol at these two institutions was strictly adhered to throughout the research

process. These included following five major ethical considerations: (i) access to participants; (ii) obtaining informed consent; (iii) privacy and confidentiality; (iv) concerns about risk; and (v) reciprocity (Creswell, 2013).

4.8.1 Access to participants.

IEN participants were accessed through the awareness strategies outlined earlier. Contact information was displayed on flyers and posters so that prospective participants could get in touch voluntarily. Snowballing technique was used for both IENs and other stakeholder participants. Preliminary contact was made to explain the purpose of the study, gain consent and organize an interview time and place.

4.8.2 Obtaining informed consent.

Informed consent was obtained from each interview (Appendix XV) and focus group participant (Appendix XVI). At the organizational level, permission was obtained from senior representatives at the study site about identification of their hospital during and/or after completion of the research.

4.8.3 Privacy and confidentiality.

Participants were given the option of being interviewed in an offsite location at the CARE Centre for IENs, conveniently accessible via public transit, or if s/he preferred, in a meeting room onsite away from the participant's immediate area of work. Participants were informed that audiotaping and transcriptions were for research purposes only. The professional service engaged for transcribing the interviews provided a statement of confidentiality (Appendix XVII). Alpha-numeric code numbers were used to identify participants. Interview notes, demographic profile and consent forms were separated from the data files. The data comprised of the journal, and all audiotapes and transcriptions (soft and hard copies) will be

stored in a locked cabinet in my supervisors' office at the University of Ottawa and destroyed by a secure shredding service, five years from thesis defence. All email communication pertaining to the research was handled separately through my University of Ottawa email address. Desktop computer, laptop, electronic data files and storage devices were all password protected. In the report, quotes have been selected carefully so as not to inadvertently identify the participant(s).

4.8.4 Concerns about risk.

Risks associated with this study were no greater than those in everyday practice (TCPS, 2013). It is possible that the interviews could present some emotional triggers for participants, especially for the IENs. Information about the hospital's Employee Assistance Plan including the contact information for the psychological counselling services was made available to the participants at the time of the interview.

4.8.5 Reciprocity.

The participants' personal insights, time and expertise that contributed towards this research process was significant. The opportunity for joint learning and creation of new knowledge is expected to be mutually beneficial for the researcher and participants. A \$25 gift card was offered as a token of appreciation to all participants; one individual refused to accept the token but the rest did so gratefully and signed the receipt (Appendix XVIII).

4.9 Summary

A qualitative methodology was selected because workplace integration of IENs is complex and has to be explored in depth within its context, with voices of IENs at the centre (Creswell, 2013). The overall methodology with its components is summarized in Figure 7.

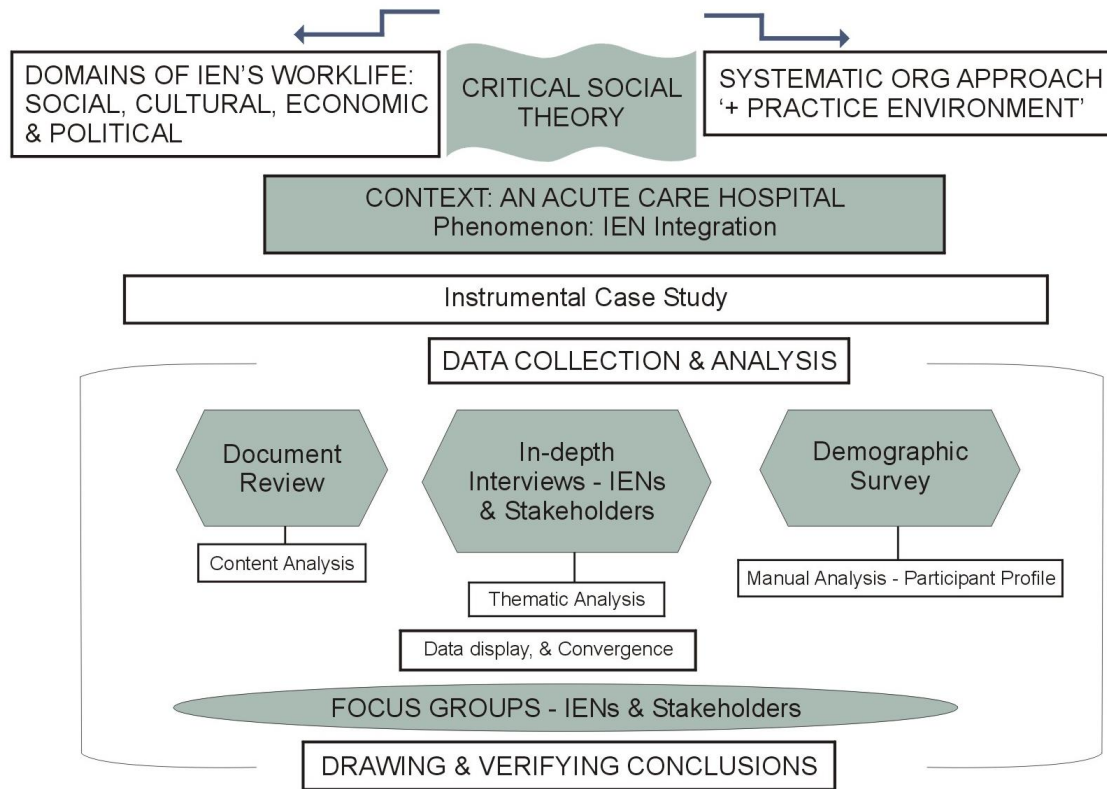


Figure 7 Overview of Study Process

This research was guided by the tenets of CST and created an empowering environment for the study participants in various ways. IENs in the study sample shared their stories and had their voices heard; some participated in validating the key findings and adding to the analysis, as well as influencing recommendations from this study. This approach is aligned with my critical social theory stance as the researcher. Informed by CST, I have tried to look beyond the immediate situation and focus on redistribution of power and resources; there is an attempt to explain how things could be, not just how they are (Kinchloe & McLaren, 2005). It is anticipated that one of the potential outcomes of this research process will be an action agenda for the case organization to pursue beyond my involvement as the researcher (Campbell & Bunting, 1991).

The next two chapters will present the study findings starting with the meaning of what an integrated IEN is in chapter 5, and the organizational factors influencing integration of IENs in chapter 6.

Chapter 5 – Results Part I: ‘Integrated’ IENs

This chapter reports on findings about what is meant by workplace integration of IENs, from the perspectives of a sample of four types of sub-cases or groups of participants, from within the main case organization: (1) IENs; (2) peers/mentors; (3) managers/directors; and (4) senior managers. The findings are presented at two levels: (A) firstly, within sub-case analysis, where the purpose is to understand workplace integration of IENs according to each of the four sub-cases or participant groups: IENs, peers/mentors, managers/directors and senior leaders, all employed at the case organization, and (B) a second level of analysis across these same four participant groups, where the aim is to gain further insights from comparing their perspectives – in other words, areas where the views of IENs, peers/mentors, managers/directors and senior managers are aligned or disparate.

All of the sub-cases, or groups of participants, have the tendency to talk about workplace integration in relation to the challenges first experienced by IENs when adjusting and adapting to the healthcare context in Canada. When they are reminded that this research focuses on IENs who have been working in Canada for at least five years, they are able to identify additional dimensions of what workplace integration of IENs means to them. These are focused at the individual level in terms of describing an IEN who is considered to be ‘integrated’ in the workplace – her/his knowledge, attitudes, feelings, behaviours and/or skills.

Relating back to the conceptual framework guiding this research, the focus of this chapter is on the IENs’ achievements when integrated, as highlighted in the bottom left section of Figure 8. The IENs’ achievements as reflected in the conceptual framework make reference to the social, cultural, economic and political domains in the IENs’ nursing work life. Having analyzed the findings according to the within sub-case and across sub-case analyses, this chapter will

conclude with how the understanding gained from this research relates to the IENs' achievements aspect of the conceptual framework.



Figure 8 Workplace Integration of Internationally Educated Nurses

5.1 Within Sub-case Analysis

The purpose of the within sub-case analysis is to understand what workplace integration of IENs means according to each of the four sub-cases or groups of participants: IENs themselves, peers/mentors, managers/ directors and senior managers. Major themes and sub-themes about workplace integration of IENs are grouped under each of the sub-cases and summarized in Table 5.

Table 5 *Within Sub-case Analysis: Summary of Themes/Sub-themes – “Integrated” IENs*

Sub-case (Groups of Participants)	Major themes & Sub-themes
5.1.1 IENs	5.1.1.1 Role clarity - Understands professional and legal framework of nursing practice - Adjusted to primary care model, holistic approach to clinical role & inter-professional team - Confidence in clinical practice, not afraid to ask questions - Understands role of nursing bodies
	5.1.1.2 Negotiated workplace culture and communication - Proficiency in English, confident in giving/receiving feedback, incl. in situations of conflict - Understands cultural context and nuances re. diverse patients, team and workplace - Comfortable, happy at work, socializes, ‘fits in’, feels supported & valued on team - Recognizes what has changed/stayed same in own cultural values - Pride in IEN identity - Camaraderie with nurses from similar backgrounds
	5.1.1.3 Expert resource and leader - Taking on senior roles, resource to colleagues, incl. through mentoring & preceptoring - Gets involved, influencing decisions - Career advancement by moving up &/or in more autonomous roles - Broader involvement in profession, incl. leadership roles outside workplace
5.1.2 Peers/Mentors	5.1.2.1 Positive interpersonal relationships - Has overcome language and cultural issues - Assertive and confident, copes with different/difficult personalities - Fitting in, getting along with team
	5.1.2.2 Canadian nursing practice - Uses patient-centred approach & critical thinking in practice - Adjusted to role & availability of MDs and patients’ family members - Recognizes implications if/when conflicts with patients/family members escalate
	5.1.2.3 Continuous learning and involvement - Involvement at policy level through committees or suggestions at staff meetings - Reflective on areas for self-improvement/professional. development - Promotes or advocates for self
5.1.3 Managers/Directors	5.1.3.1 Engaged with team - Communicates effectively in English (social & professional) - Adjusts to different teams/context - Fits in as perceived by self and others - Understands self-regulating, autonomous nursing role & how it relates to MD role - Effective utilization of inter-professional team
	5.1.3.2 Embraces opportunities for leadership - Mentoring, coaching, contributes to others’ learning incl. about cultural issues - Experiences other advanced areas of clinical practice - Has learned diplomacy in order to influence others
5.1.4 Senior Managers	5.1.4.1 Appreciation of cultural diversity - Understands complexity of cultural nuances - Accepting of diverse value systems
	5.1.4.2 Employee satisfaction - Wants to stay with organization over long term/retention, recommends workplace to others - Readily identifies as IEN
	5.1.4.3 Demonstration of leadership - Gives back to profession, supports others’ development - Advocates for self in pursuit of professional development & career aspirations - Understands the broader healthcare system

5.1.1 IENs' conceptualization of their integration in the workplace.

Even though each of the IENs in the sample has been practicing in Ontario for an average of 10.9 years, they have a strong recollection of their initial adjustment to nursing in Canada. Becoming integrated in the workplace is described by IENs as the phase when the IEN has overcome most or all of the difficulties faced in the earlier transition phase of getting oriented and adjusted to nursing in Canada and then moved beyond. Three broad themes emerge in how IENs speak about what workplace integration means to them: (i) role clarity; (ii) negotiated workplace culture and communication; and (iii) expert resource and leader. Each theme is further explained in the next sections, using the IENs' own words.

5.1.1.1 Role clarity.

The theme of role clarity addresses the various ways in which nursing is different in Canada than in the other countries where IENs may have practiced. Aside from the scope of professional practice and the legal accountabilities of nurses, it also refers to the differences in models and philosophies of nursing care, as well as nurses' relationships and access to physicians and other members of the inter-professional team.

The professional and legal framework within which nurses have to function in Canada was one of the major areas of learning for IENs at the beginning:

But sometimes I also tell other IENs that you know, whatever your experience or your training, wherever country you came from, you cannot just directly apply it here, because this is a different environment. Even though nursing in general is all the same but there are some protocols that we have to follow here (participant I014).

IENTs talked about being clear and confident about these professional and legal obligations, including functioning as an autonomous professional if one has transitioned effectively and is now integrated:

[Nurses] have a lot more autonomy and they're expected to ...like we'll get the doctors asking us, well, what do you think? ...they trust you as a professional to make decisions ...your scope of practice is actually bigger here ...you're doing the blood work, you're listening to the chest, and you're doing everything (participant I001).

While the adjustment to the clinical role was not as significant for some, there were models of nursing care that the IENs had been accustomed to in their previous work experiences which were different from those in Canada. For example, one IEN said:

There's really no difference in terms of the workload because it's the same kind of function every day that we do. We do assessment, we interpret test results, advocate. There's really no big adjustment for me on that part because I've been doing that already in the Philippines. I think the only major adjustment that I had to do is that we had a different way of charting [about patient's status and nursing care] here (participant I008).

Another IEN describes her adjustment from team-based nursing to a primary nursing model:

Back home, we have the nurse only for specific things...When the patient comes, the patient leaves, that is one nurse. Another nurse takes care of all the orders from the doctor, the other nurse for the IV, okay... But here, you only have four to five patients. But you have to do everything for the patient... Actually here, the nurse works with the patient 24 hours. They know the patient better than the doctor (participant I020).

Working within the context of an inter-professional team where each member has a unique role and contribution to make and where nurses are valued as active players, was highlighted by many IENs as different from what they were used to:

Here [in Canada], we have people who have to sit down as a team and we decide what's the best approach to let's say discharge planning...So everybody's involved. To me, at the beginning, I didn't understand this, like what exactly their roles are and why it's so important but later on, I can see more clearly. So when I understand how the system works altogether, because nursing is pretty much simple, anatomy everywhere is the same, well, so you understand how the things are done but when you actually become a part and then you integrate in it, that's how I would see it (participant I028).

Another participant describes the IEN who has integrated in the workplace as one who collaborates with the team: "She gets along...with her colleagues, she knows how to talk to nurses, to the doctors. She knows how to, as a nurse, critically think and make decisions for her patient's wellbeing" (participant I012). One IEN emphasized being valued as a contributing

member by the rest of the inter-professional team: “Integration means for me...you feel like you are being one with the healthcare team and ...your skills and your judgment is accepted by the team and...they value your skills, your judgment” (participant I015).

With more experience and understanding of the role, IENs spoke about being less afraid to ask questions: “Asking questions...Yes, it’s okay not to know; because it’s just okay not to know” (participant I027). Similarly, another participant noted that an integrated IEN feels less anxious about coming to work: “That means, when you come to work, you’re not afraid this, afraid that, you know. And everything is like routine, it’s normal. You have good relationships with everybody, patient, family, and all the team” (participant I020). This anxiety stems from fear that one may be asking many questions and would appear as not doing the “right” thing:

That anxiety feeling that I might be not doing the right thing... [Now] I can express myself openly... I can express myself openly without thinking what the people around me will think, so...I don’t feel inferior anymore. I have become part of the group (participant I017).

Understanding the broader nursing community, its various institutions and how they all relate to each other is another aspect of role clarity that IENs have when they are integrated, albeit at the level of the healthcare system:

For example, it took me a long time to understand the role of union or [regulatory] college or kind of your rights and your responsibilities...what is the RNAO? And these are the questions that I didn’t dare asking before I was confident...didn’t want to sound stupid (participant I027).

The theme of role clarity points to the multitude of differences that IENs have grasped about nursing in Canada by the time they have integrated in the workplace. Despite meeting the entry to practice requirements before getting hired to work, the IENs describe the many subtle nuances about the role that have to be understood, without which social closure could be created by peers viewing them as incompetent.

5.1.1.2 Negotiated workplace communication and culture.

The theme of negotiated workplace communication and culture addresses the complexity of becoming proficient in English, layered with the context and nuances of the diversities in the cultures of patients and co-workers, as well as the case organization overall and its various parts.

Becoming proficient in English was a major hurdle for many of the IENs, even those who perceived themselves as having come to Canada with English language skills as described by this participant:

When I was new, they said I don't speak English well. They questioned my skills. As if they don't trust me. That gave me motivation to improve. Now that I have integrated ...those people who motivated me, now they applaud me for where I have reached now... (participant I017).

Equating proficiency in English with nursing competency was recognized by many as unfair, but a reality that had to be overcome:

But like when I just started, sometimes in the unit, I'm like among colleagues, especially when you're new, and your language is a problem...some people, like they will think, when you can't talk properly, they think you're stupid... communication is very important, it's the key (participant I022).

While proficiency in English is a major achievement for those who have to learn it as a second language, the added dimension of understanding the cultural context and nuances is also challenging for those who are first language English speakers from other countries. As described by the participant in the quote below, workplace integration implies understanding the Canadian slang, idioms and terminology, as well as being culturally appropriate so that IENs are able to interact more fully with others:

When they're comfortable to communicate with people, even if it's not their first language, they're still able to communicate effectively and you know, it sounds silly but you know, they're able to joke with people and, and they get like the culture and the humour and they're able to sort of participate in conversations... (participant I001).

Aside from social conversations and interactions, the cultural dimension also has a practical and professional relevance, as explained by this participant:

There are some terminologies that she cannot pick up, that she's not used to hearing from her home country... for example in referring to this new hire, this other colleague of mine told me, can you talk to her because I told her to strip the bed but I saw her, she went in the room but she didn't touch the bed so I don't know if she understood what I'm trying to tell her (participant I014).

The level of diversity amongst colleagues and patients in the workplace in Ontario is a new experience for many IENs. When IENs are integrated in the workplace, there is a recognition that the learning about cultures and the sensitivity required in dealing with people is a continuous process:

There are a lot of them [patients from diverse ethnic background] here because the cultural difference we can say that there are all kinds of patients from different countries ... some of them don't speak English, no Chinese...we have to take care of them here, right... That is the big difference from back home (participant I020).

IENs who are integrated in the workplace are expected to understand diversity in its various dimensions. IENs also acknowledge that this type of sensitivity and learning is required of all nurses at the case organization, including their Canadian educated colleagues:

So when you speak to these street people, they have their own language, right...they talk to you in such a way that you don't understand it, they probably, they're trying to say something to you but because they're using a street word, you won't understand...even if you're Canadian (participant I013).

Through the process of adjusting to the Canadian environment and integrating in the workplace, there is a change that comes about in the IENs' openness to diverse cultural values and norms:

Because back home, we seldom work with different people...but then [once] you have integrated, you don't look that they're different...you're not racist...you respect that regardless of their backgrounds...cultural or sexual orientation, religious background...talking about St. Mike's, because we have diverse people here (participant I017).

Similarly, another participant describes how workplace integration is when you recognize that as an IEN, your culture and values are in a dynamic state and may change as well:

When you're an IEN, you come from somewhere, you come with several different cultures and values that you want to integrate with...some you will drop by the side, some you will redefine, and some you will refine. You know, it's all part of the integration (participant I012).

Being accepting of others' culture but also being comfortable about one's own values and beliefs is described by another IEN as workplace integration: "So in my mind being really well integrated and you're able to accept the culture of this country and of the workplace but you're also able to own your own culture that you brought with yourself" (participant I027). Within the diverse workplace setting, much of the learning is about how to give and accept feedback and ways of dealing with conflict. One of the participants emphasizes this about IENs who are integrated: "[she] knows when to talk, you know, like ...be pleasant or polite...if there's a problem, you should be straightforward with the issue, approach the person instead of going behind their backs, you know, things like that" (participant I012).

For IENs, workplace integration also means when you feel you are just like everyone else: "I'm like everybody else. I don't stand out or I'm not different or lacking anything in any way" (participant I027). Fitting in and feeling "Canadian" is emphasized by most IENs:

I don't feel like I'm a Filipino anymore, I feel like I'm Canadian and ...I'm working as a Canadian. You know, I forgot the way or how to be a nurse in the Philippines. Though there are moments when I still have to compare (participant I013).

Similarly, another IEN states that when you are integrated in the workplace, where you had your nursing education is not as relevant anymore:

Like it really doesn't matter, we just all blend in. And we help each other like if there's something that I knew based on my experience in the Philippines, then I would share it with them.... But to tell you the truth, it really does not matter in the workplace if you're educated abroad or here (participant I008).

Getting along with everyone and having teamwork is part of workplace integration for several IENs: “With my colleagues, we get along easily. The differences you can tolerate, you know, as time goes by, you get to know their personality...of course there are racial differences ... but as long as you respect each other” (participant I011). The many differences in personalities and work ethic do not make teamwork easy to achieve all of the time; workplace integration is described as when you are able to cope with such dynamics:

I have a standard ... when you come to work, it's not coming there to wait for the time for you to get paid...but some don't do their job properly and they keep complaining...and they're kind of like bad mouthing you...So I don't want to work with that kind of person. But I don't flare up; I just step out ... you still want to keep the professionalism and respect for each other, right (participant I013)?

Socializing with colleagues at or outside work is a part of fitting in with the team for some: “I'm comfortable with what I'm doing. I have the full support of my manager; my co-workers like me...and I care for them as well. I organize lots of parties and they come. I go to their parties as well” (participant I013). While language and culture are important factors in being able to socialize with work colleagues, some IENs also describe workplace integration as when relationships with team members turn into friendships:

Before I probably was a little bit shy say my English wasn't fluent enough to communicate with people. I wouldn't understand a joke or two but now I have no problem and I know people ...they're completely fine with me... So it's not just the team, it's a friendship (participant I028).

Other IENs find more ease in socializing with those from a similar cultural background:

You know, for me, it's really hard. Because even in my own language, in my own country, I'm kind of just like sitting there, listening. Not really talking to the person. But then at least we have same background and when they talk, I know a lot of things in the background, right (participant I021).

For many IENs, having the support of another IEN from a similar background is especially meaningful in the earlier adaptation phase when first transitioning into the Canadian workplace:

He was easing up for me to get into the team by just, you know, making some suggestions to me in terms of, okay, this is done this way, our approach is different than it's done back home. So he helped me to, to learn how things are done...he's from Russia as well (participant I028).

When IENs are beyond transition and have become integrated in the workplace, being able to connect with other nurses with similar backgrounds continues to be important for some IENs: "From my own experience... we still come to like our own group, like Chinese, we go to the Chinese group and the Filipino, there they go to their own group" (participant I021). IENs talk about how at the point of integration, they are comfortable and happy, and they feel supported and can be themselves, especially when interacting with colleagues from a similar cultural and language background amidst a diverse team:

Like our floor, we have lots of Filipino nurses...I feel like they are more comfortable or feel more support from the peers because they are all from the same country and the work definitely is different...you're not feeling like... excluded or isolated (participant I022).

According to some participants, this camaraderie with nurses from one's own background is negotiated within the broader diverse team context; it evolves over time and comes with being integrated in the workplace:

They don't mind. Because sometimes we ask them, you don't mind if we speak our language, oh, I don't mind. Or maybe they get used to us already. Because there's a lot of Filipino in our unit...and sometimes they want to learn our language too (participant I011).

Another participant describes how in addition to feeling like she can be herself or be comfortable with her own cultural and faith identity, workplace integration is also when her peers and team members are accepting of her as being different:

I'm able to keep my culture as well. I didn't lose who I am just because I am integrated. So with the team that I work with, that's also part of our culture that we are still deemed as individuals...I'm never judged for being who I am. I'm from a different religion but everybody knows it and I always got the day off when I needed to and I didn't need to explain or feel judged by it (participant I027).

The theme of negotiating workplace communication and culture has several dimensions which are critical to the IENs' sense of belonging in their various teams at work. The resultant sense of relief and feelings of being comfortable and relaxed as valued team members is a major undercurrent for this theme. This may relate back to Lukes's (2005) first or overt dimension of power where the onus to participate is primarily on the IENs' ability to understand and adjust to the team.

5.1.1.3 Expert resource and leadership responsibilities.

With years of nursing experience both prior to immigration and since working in Canada, there is much that IENs contribute. The theme of expert resource and leadership responsibilities highlights the various ways in which IENs get involved more broadly in influencing policies and practices and helping others learn and develop.

The IEN participants talked about how integration is about taking on more senior roles in the team and being valued as a resource to colleagues:

I'm a senior staff, others look up to me, like if there's an issue that needs to be addressed and they ask me any recommendation or they need my help, then I could supervise them. I've been alternate for the last like five years as a charge nurse, unit leader...supervising the staff (participant I015).

Workplace integration is getting involved in organization-wide initiatives or projects which not only allows for leadership development, but also exposure to others' perspectives and experiences:

A special project every year... and that you may or may not join is fine. But it's always nice and a good opportunity to immerse and integrate yourself to the whole hospital; not only to your unit, but to the whole hospital... because when, in the meeting, when we are

sitting beside each other and you were sitting beside an employee who is working in the ICU, they have their different perspective, right (participant I013)?

Taking initiative and facilitating processes to make changes in clinical routines or protocols is another way that an IEN participant describes herself as having influenced nursing practice in her workplace, as well as more broadly in the field: “So I got that changed, I was a change agent in that...now it’s routine...so eventually, well, even now, according to the College of Nurses, for the Canadian Pain Society, pain is the fifth vital sign which is good...” (participant I012).

While integration to some means moving up the organizational or career ladder, for others it is taking on different or more autonomous roles:

The opportunity for this job was given to me by my manager and the medical directors. They asked me if I wanted to do it based on my experience and years working with the team and skillset that I have...I have always been involved with like the service development and initiatives. I did a fellowship with the RNAO, like it’s just always seeking opportunities I suppose (participant I027).

Providing leadership or being an expert resource may also include giving back to others – for instance, through mentoring IENs who are starting out:

Because we also have challenges when we came, during our time and seeing this happens still at the present, we want to help those nurses that are going through these challenges right now too, for them to better succeed in their profession and be able to work as a nurse (participant I015).

Being a preceptor to students and/or a mentor to newly hired nurses is another way in which IENs who are integrated in the workplace demonstrate leadership: “The teaching opportunity, one is to be the mentor for the new staff. Sometimes we have a new program, like when we got a new dialysis machine. I was what we call the ‘super user’...” (participant I021).

Taking an active role more broadly in the profession and within the nursing community is also part of integration, even though it may extend beyond the workplace: “I would be active with the union...and with the nursing council...We went to the RNAO, there was a rally last

year... So that was mostly for the hiring of more RNs campaign from RNAO” (participant I015). Similarly, another IEN participant describes pursuing opportunities to lead outside of the workplace as being integrated: “I started volunteering for RNAO and I’m on the executive [committee] of my region...The president told me that I should apply to take her position” (participant I012).

This theme of expert resource and leadership responsibilities emphasizes how when integrated in the workplace, the contributions made by IENs’ can extend beyond their teams and units to across the organization, as well as into the profession at large. The knowledge and confidence gained over the years is empowering and leveraged for broader impact.

5.1.2 Peers/mentors’ views on integration of IENs.

Similar to the IENs, it is difficult for their Canadian educated peers/mentors to focus on what is meant by workplace integration without referring back to the challenges their IEN colleagues had in the early transition phase. Themes related to positive interpersonal relations with the team by overcoming communication barriers and gaining overall confidence and familiarity with Canadian nursing, specifically differences in the role and scope of practice, re-emerge with peers/mentors. There is also the notion that the integrated IEN is open and willing to accept support and takes an active part in her/his ongoing learning. These themes are elaborated further in the sections below.

5.1.2.1 Positive interpersonal relationships.

This theme of positive interpersonal relationships emerging from the perspectives of peers/mentors who are Canadian educated nurses, focuses on the IEN getting to the stage of having overcome the hurdles of English language proficiency and orientation to the professional and workplace culture here in Canada. Language and cultural issues are emphasized as key

factors in workplace integration of IEN's, especially as they relate to interactions with team members:

They're [IENs] more confident, familiar with the language, the lingo that we're using in nursing areas... because they can communicate better; they're able to work well. They can work better with the other nurses. And there are less judgmental behaviours or attitudes (participant P002).

Tied closely to language skills and cultural familiarity is the IEN's overall confidence. Peers/mentors discuss how this helps the IEN become more assertive: "They [IENs] are not nervous or anxious, right. They're kind of more confident. You can see it in them... with experience, you get more comfortable" (participant M004). Confidence also allows the IEN who is integrated to have her/his presence felt more by colleagues as opposed to keeping to oneself: "...be more assertive and be more visible with your coworkers rather than just working on your own and not communicating well" (participant P002).

Workplace integration involves learning about individual co-workers and coping with different personalities: "...the connection they have with the other staff members... when they start new, there are fewer people they know but along the way, they get to know more people and they kind of know who is helpful...who is not really helpful" (participant P010). Fitting in and getting along with the team is also echoed by peers/mentors as a factor linked with workplace integration:

To me, that [workplace integration] would mean they [IENs] have gotten the lingo, you know, they fit well into our program...because they're coming from another country, they have all the education...but I think for me personally speaking...in the beginning, you'll say, okay, they come from such and such a country. Then you kind of put it in the background and you totally forget, you think of them as your colleague (participant M004).

Becoming confident and assertive in their interactions with nursing and inter-professional colleagues is seen as a positive achievement and an important aspect of workplace integration of

IENs. Peers/mentors attribute language proficiency and cultural familiarity as key pre-requisites. This theme may be alluding to Lukes's (2005) latent or third dimension of power, implying there is a dominant norm that IENs have had to strive for.

5.1.2.2 Canadian nursing practice.

Even though the peers/mentors are Canadian educated, most have many commonalities in their backgrounds and personal experiences with the IENs themselves. Four out of five of the peers/mentors migrated to Canada during their teenage or young adult years from some of the same countries as where the IENs originate. The theme of Canadian nursing practice refers to the peers/mentors' insights about the differences in how nursing is practiced in Canada, with an emphasis on the role of physicians, family members, and a more consumeristic healthcare culture.

Peers/mentors highlight how the role and availability of physicians impacts the nursing role and requires significant adjustment:

Nurses and doctors are working together, it's not like [doctors are] here during the procedure only. You're working together, the doctors always stay in the same ward, their offices are just beside us... it's not like here [at SMH], you know, PRN [standing order] right? There we have doctor's order but the order is only for the one time use or even whenever the doctor tells you, just one time use...much less medical, or critical thinking needed by nurses... in Canada we can give PRN drug any day by using your critical thinking and knowledge... (participant P016).

The extensive involvement of family members and the sheer size of the patient population in other healthcare systems necessitate specific adjustments for the IENs in their practice in Canada:

Nurses here are more focused on patient's personal care, more psychosocial, patient-centred care...and not only giving medication but also health education to help patients...There is a huge population in China. We have no personal care... there is no diaper changing, no bed bath...even emptying Foley catheter's bag...it's all done by the family member (participant P016).

Another peer/mentor participant highlights how an integrated IEN understands the consumer oriented healthcare culture in Canada and recognizes the broader organizational implications of her/his actions when it comes to dealing with conflicts with patients or a family member:

How they [IENs] solve a problem or handle the situations here is also a very important part and it [a conflict] could go above them [escalate to management level] too if they don't know how to handle or how to get help, how to get support. So the problem with the patient or with the family is also a problem for the organization as well (participant P010).

Peers/mentors reinforce the differences about nursing in Canada that IENs have grasped when considered to have integrated in the workplace.

5.1.2.3 Continuous involvement and learning.

The theme of continuous involvement and learning addresses peers/mentors' expectations that when integrated in the workplace, IENs participate in discussions about changes or improvements in organizational and program policies, support others in their learning, and pursue educational opportunities for their own professional development.

Aside from taking on team leader responsibilities and preceptoring or mentoring new nurses or IENs, peers/mentors talk about the nature of workplace integration when the IEN becomes involved more broadly at a policy level:

They're being involved with or starting to ... in the nursing committees, like nursing education and practice committees. They're more involved in policy making. They're involved in ...voting for new leaders and they can discuss more about policies, the pros and cons (participant P002).

In addition to participation on committees, other peers/mentors describe greater involvement in informal ways, such as at staff meetings: "During the work, we [staff nurses including IENs] often share our experiences. We usually have staff meeting to share opinions... about how to improve our protocol or policy" (participant P016). Peers/mentors highlight that the integrated IEN demonstrates an ongoing interest in self-improvement: "And they're [IENs] eager to

learn...if we find they're doing something wrong and you kind of show them the policy and tell them, this is the way to do it, they're accepting of it" (participant P010).

Taking advantage of ongoing professional development requires the IEN to be reflective about her/his learning needs and to be able to self-promote in order to access the opportunities. According to Lukes's (2005) theory, this change might imply the IEN learning about unspoken rules and overcoming imbalances created by covert power.

5.1.3 Managers/directors' perspectives on IENs who are "integrated".

The perspectives shared in this section are from the point of view of nurse managers from three different clinical areas in the hospital, as well as three other leaders who are in roles where they have had direct involvement with the orientation and support of new and diverse staff, including initiatives specific to IENs and IEPs. While the perspective of this group is slightly more conceptual, the specific theme describing IEN's engagement with the team is echoed. Embracing leadership opportunities, including mentoring other colleagues, are additional themes highlighted by managers/directors. These themes are further explained below.

5.1.3.1 Engaged with the team.

The emphasis in this theme of being engaged with the team is based on the managers'/directors' expectations that IENs who are integrated in the workplace have mastery of the English language and workplace culture, that they are able to fit seamlessly into the various teams they might belong to, and that they are able to interact effectively with physicians and the rest of the inter-professional team. Effective communication skills in English are an expectation when an IEN is integrated in the workplace. Managers/directors highlight this as critical in terms of the IEN's ability to function in her/his role and be accepted as a member of the team: "If English isn't their [IENs] first language, it's a barrier and a challenge for them. So trying to

ensure that their knowledge and what they know is being clearly communicated to other members of the team” (participant L009). The importance of English proficiency is highlighted for professional as well as social communications: “Like knowing when to use slang words as opposed to formal language, which could be fine with your colleague, but inappropriate with a patient or something along those lines...or inappropriate with a supervisor but not inappropriate with your colleague...right?” (participant L005).

According to managers/directors, “fitting in” is related to forming relationships: “Do you feel you fit in or are you still thought of as an IEN... The IENs that I work with, if I didn’t know that they practiced elsewhere or they got trained in a foreign country...now, I wouldn’t know” (participant L003). There is also the recognition that the culture of teams is not uniform across the organization, and so workplace integration is when IENs are able to adjust to each new team context:

Integrating with the culture and being able to get along with the team and understand sort of the uniqueness of one program, one unit over another. Every team you work with, the culture’s completely different...and the dynamics are totally different...so being able to integrate into that (participant L019).

Another manager/director reinforces “fitting in” as a marker of workplace integration, but that it cannot be just a form of self-assessment by the IEN. The other team members’ perception of how well the IEN is accomplishing this is also an important factor:

Forming relationships with people from other backgrounds... So that to me is part of workplace integration...so their [IENs] ability to form relationships...feeling part of the team, that’s number one. And that’s very much a self-assessment that occurs...their ability to function effectively both as an individual and as part of the care team...and how they’re viewed both by themselves and by others as members of the team (participant L005).

According to nurse managers, integrated IENs are very aware of the requirement that they function as self-regulating, independent practitioners within the Canadian context: “Familiar

with what our practice standards are...also it's the expectations on them [IENs]... This is how we did it where I worked before, or where I did my training. But here, you do it very differently" (participant L009). Understanding roles and tapping into the expertise of the inter-professional team is important as IENs get integrated into the workplace: "What a social worker does, what is a discharge planner or a case manager, pharmacist... it's not just the nursing piece because everybody's part of the team and is a part of the circle of care" (participant L003). The ability to relate to physicians as members of the team is emphasized by another nurse manager: "I think one of the hardest things for the IENs, it's ...with regards to communicating with physicians for instance...the way we advocate and is it okay to override a physician order... I'm advocating for my patient" (participant L003). Another manager underlines how an integrated IEN recognizes the importance of the team from a patient safety perspective and does not hesitate to use or rely on the rest of the healthcare team:

Newer staff are sort of working a little more independently, they're not utilizing the team as much, they're a little bit quiet...I don't feel like they've fully integrated yet...observe like a code blue [cardiac arrest] happening...a critical situation happening and you see how people kind of react and that... it's okay to ask for help, it's okay to, you know, panic and yell at somebody to go do something...it's an expectation from a patient safety perspective (participant L019).

The theme of engaging with the team highlights the importance that managers/directors place on knowledge of the nursing role in relation to other members of the inter-professional team, and proficiency in English in order for IENs to be integrated in the workplace. This theme may be reiterating Lukes's (2005) notion of overt power, whereby as long as the IEN understands and adheres to the "rules", s/he may fit in and belong when integrated in the workplace.

5.1.3.2 Embraces opportunities for leadership.

The theme of embracing opportunities for leadership is what managers/directors perceive as a natural progression for IENs beyond adaptation to the workplace in Canada. It includes different ways in which the IEN makes a broader contribution in terms of sharing their knowledge and expertise, through mentoring and coaching others, and through advancing their own professional practice. The theme also includes how, from a cultural knowledge point of view, IENs recognize their need for sensitivity to the diversity in patients, but are also comfortable with the role they can play as cultural brokers for their colleagues.

Mentoring and coaching others are common ways in which managers/directors describe leadership opportunities embraced by IENs who are integrated into the workplace:

IENs that are in leadership roles are actually mentoring and coaching other students or other new hires, Canadian nurses... because they have I guess transitioned or integrated so fully to their Canadian role...if that nurse that they're mentoring didn't know that they were foreign trained, they wouldn't be aware (participant L003).

Moving into other clinical areas to advance their practice is also another way for IENs to demonstrate their leadership according to managers/directors.

The opportunity is there for them to go and step into leadership roles, to advance as much as they want to advance with regards to transitioning even from the practice area that they're practicing in to other practice areas because there are fellowships that are offered...There's a fellowship in wound care, a fellowship in palliative care, a fellowship in any other service that they may be interested in (participant L003).

The potential for IENs to influence others when they are integrated is highlighted by this manager/director participant using the metaphor of a sponge:

I think that it's not only the onus of the IENs to learn new ways of doing things but also to teach new ways of doing things...So the first phase [when newly adapting] is more the IENs being a sponge and soaking in all kinds of new information, new learning, but the second part is [IENs] squeezing their sponge and releasing their own knowledge for others (participant L005).

This manager/director goes on to specify that contributing to others' understanding of cultural matters related to patients' health and wellbeing and changes in approaches to care is an important expectation of IENs who are integrated in the workplace: "When they're able to express themselves and let us, let people who have been here longer know that this is happening and that this is how it is in their culture, right... yeah, influence practice, right" (participant L005). Finally, having learned diplomacy within the context of local workplace culture is another dimension of how integrated IENs communicate:

The most valuable outcome is that your idea is listened to and that it's seriously considered as a potential for improving quality in your environment...so my advice to IENs is to learn diplomatic and strategic language for when they're approaching both colleagues and supervisors with ideas from their home country or from their experience (participant L005).

This theme outlines mentoring and coaching, more advanced practice roles, and being a cultural knowledge broker as ways for IENs to embrace leadership opportunities. Again, while this perspective of managers/directors seems quite honorable, it could also be seen as another imposition on what IENs need to do or how s/he needs to "lead" in order to be effective.

5.1.4 Senior managers' views on "integrated" IENs.

The perspectives shared by the three senior managers are predominantly from an organizational vantage point and are included in chapter 6. A few specific themes focused on what it means for an IEN to be integrated in the workplace at the individual level emerge from the senior managers' perspectives. Themes include: appreciating cultural diversity; employee satisfaction and retention; and demonstrating leadership by giving back to the profession and pursuing opportunities to continue to grow professionally.

5.1.4.1 Appreciation of cultural diversity.

The theme of appreciation of cultural diversity refers to the senior managers' emphasis on how IENs who are integrated in the workplace have become aware and sensitive to matters of diversity within their patients and families, as well as their co-workers. Similar to that what has been reported by the other categories of participants, the senior managers emphasize how beyond the technical knowledge and skills required to do the job, the extremely diverse Toronto context adds to the complexity of cultural nuances for IENs who are integrated in the workplace:

I guess there's a knowledge piece and there's a skills piece. And then a third is the cultural issue...we have our Canadian culture and our Canadian way of thinking and interacting with each other as a society...Our situation is so diverse that it's not just the Canadian context, it's the fact that the Canadian context is really complicated because there isn't one in Toronto for, you know, it's not like one thing I have to figure out, I actually have to figure out a whole bunch of different things (participant L024).

Becoming aware of cultural differences and accepting diverse value systems are described by another senior manager as part of the integration process:

I remember from my days, [when I was] responsible for the obstetrics unit and we had lots of nurses who were very judgmental towards some of our street folks. Particularly, street workers who were in for some reason usually of a pregnancy, delivery or whatever...the manager had to be very sensitive about the fact that this is different than from the Philippines and there are different norms and values and expectations (participant L025).

In discussing this theme of appreciating cultural diversity, the senior managers start to raise the relevance of the external community and patient demographic context to workplace integration of IENs. It also speaks to how the "Canadian way" is not a static notion, and it is not necessarily comprised of just one dominant way.

5.1.4.2 Employee satisfaction and retention.

The theme of employee satisfaction and retention includes how IENs make positive references about their employer organization to external stakeholders when they are integrated in

the workplace. According to one senior manager, when IENs talk positively about their employer and readily highlight their high level of satisfaction to other colleagues or community members, they are viewed as being a strongly committed and integrated member of the workplace:

The ten nurses, the IENs that had worked here for some time...when they were talking to me about their experiences here and how supported they felt...they were telling others about what it means to be an IEN at St. Michael's...I see their enthusiasm and their individual and professional success, then I know we've been successful (participant L018).

Employee retention or the IEN staying with the organization over a long term is viewed as a marker of workplace integration by senior managers:

They're [IENs] very grateful and they stay grateful for a long time. So they then in turn become committed to the organization and to our mission and support our initiatives. So it's a win for the organization as well as hopefully for the staff (participant L024).

Being satisfied and remaining in the employment of the same organization over the long term are important measures of workplace integration of IENs according to this theme from perspectives of senior managers.

5.1.4.3 Demonstration of leadership.

The theme of demonstration of leadership from the perspectives of senior managers refers to how IENs support other colleagues to develop, contribute to the broader healthcare system and be able to pursue their own career aspirations. Workplace integration is more than getting adjusted, it is being satisfied and working to the fullest. At the senior management level, the idea of giving back to the development of others in the organization or the profession is also important: "When we did the mentor/mentee program...the nurses [IENs] stepped up and wanted to be part of it because they trusted this organization was going to stand behind its strategy and its mission and its vision" (participant L018).

Senior leaders speak about how being able to advocate for her/himself to be able to pursue professional or career aspirations is a marker of IENs' integration in the workplace:

IENs, again because they sometimes come from cultures where they need permission...they're not used to advocating for themselves, so we created a booklet that we give to all of our nurses that outlines all of the [educational] opportunities and we make it very clear, it's for every nurse that works at St. Michael's (participant L018).

Leadership in the context of workplace integration of IENs is not limited to the confines of the employer organization, according to the perspective of one senior manager. When the IEN is growing and developing to her/his optimum level, and is able to pursue career goals and aspirations that go beyond their current workplace, that is also a demonstration of leadership:

So as I say, if a nurse wants to start in a general area and move to critical care, they can do that at St. Michael's. If they want to work in the community, they can do that. And so I look at integration beyond St. Michael's, I sometimes will actually even encourage them [IENs] to go to another organization that has programs and services that are aligned with their true passion and vision. So integration at the end of the day, that people get up and go to work where they feel they can maximize their full potential (participant L018).

Finally, an understanding of the broader health care system and how the IEN's workplace organization is impacted by the external environment demonstrates a form of leadership:

To be integrated within the whole healthcare system. So when we hire a nurse, my job is to make sure that they understand as much as possible the Ontario healthcare system but particularly how that system is relevant to St. Michael's Hospital ... (participant L018).

Aside from providing support to others' professional growth, this theme also places emphasis that demonstration of leadership by the IEN who is integrated in the workplace includes advocating for her/himself and pursuing development opportunities beyond the employer organization. Understanding the broader healthcare system and its impact on its various members, especially the IEN's workplace organization, is seen as part of demonstrating leadership.

5.2 Across Sub-case Analysis

The data was re-examined for areas of convergence and divergence between the four sub-cases or groups of participants. Themes from the within sub-case analysis were collapsed in this section into three broad ones: (i) being a “Canadian nurse with international experience”; (ii) progressing on the leadership journey; and (iii) perseverance in overcoming challenges. Table 6 shows how the sub-themes are clustered with those highlighted by all/most sub-cases at the top.

Table 6 Across Sub-case Analysis: “Integrated” IENs - Summary of Themes/Sub-themes

‘Integrated’ IENs	IENs	Peers/ Mentors	Managers/ Directors	Senior Managers
5.2.1 Being a “Canadian nurse with international experience”				
Communicates confidently in English, understands cultural nuances & diversity - less anxious/conscious, gives/ receives feedback and deals with conflict effectively, diplomatic to get ideas across for change	x	x	x	x
Fitting in, sense of belonging, feeling “Canadian” (not thought of as IEN), relaxed/open/socializes with colleagues, valued on team	x	x	x	x
Grasp of role/scope of nursing practice in Canada – patient/family centred approach, autonomy – critical thinking/problem solving, confidence in relating to physician, seeks out inter-professional team	x	x	x	
Pride in IEN identity – feels respected as IEN, values higher status of nurse, refines some of own values – “owns” own values, not thinking re. ” how it was back home” as much	x		x	x
5.2.2 Progressing on leadership journey				
Expert resource/role model- cultural interpreter/broker, advanced clinical practice, team lead, special projects, fellowships, mentoring, preceptoring, influences policies & practices/others - “squeezes sponge”, understands process and culture of change	x	x	x	x
Commits to lifelong learning, advocates for self in pursuing opportunities, appreciates professional growth from leadership roles	x	x	x	x
Satisfaction with professional capacity/growth, wants to stay with organization over the long term	x			x
Involvement with professional association, union, awareness of larger healthcare system, broader nursing institutions	x			x
5.2.3 Perseverance in overcoming challenges				
Being judged - based on English proficiency, accent, and cultural norms re. assertiveness, self-promotion, diplomacy	x	x	x	x
Preparedness of workplace for influence by IENs	x	x	x	
Personal and/or family commitments	x	x		
<i>Note: Bolding and size of the “x” indicate relative degree of emphasis</i>				

5.2.1 Being a “Canadian nurse with international experience”.

This theme encompasses a number of notions mentioned by all of the sub-cases or groups of participants which all refer to the IEN “settling in” from a professional, social and cultural perspective. Having adjusted and become confident about the role and the scope of the practice of a nurse in Ontario is one of the main ways in which all sub-cases describe an IEN who is integrated in the workplace. The IENs place the most emphasis on this theme, whereas the senior managers are the least focused on this. Both the IENs and the peers/mentors describe how the interaction and relationship with physicians is one of biggest differences faced by IENs. Nurses’ level of autonomy and the need to use critical thinking skills is generally greater in Canada than where many of the IENs have worked prior to their immigration to Canada. The respect awarded to nurses and the valuing of their contributions by the inter-professional healthcare teams is highlighted by both the IENs and the managers/directors.

The managers/directors suggest that an integrated IEN is one who understands the role of each of the team members and is not hesitant to ask for support from them. Additionally, s/he recognizes patient safety concerns that can emerge in critical situations if the right inputs from the team are not sought out in a timely manner. While the majority of IENs are comfortable with the involvement of family members in providing personal care and emotional support to the patient, the peers/mentors note that having the patient and his family at the center of the decisions about care is what is new for many IENs. Consequently, when an IEN is integrated in the workplace, s/he consistently applies a patient and family centred approach to nursing care.

All of the four sub-cases or groups of participants describe being proficient in English and understanding the cultural nuances embedded in the verbal and non-verbal cues, as being an important part of workplace integration. The IENs and managers/directors describe how critical

communication is in building relationships with colleagues. Some colleagues often equate lack of English proficiency and ineffective communication skills to incompetence in nursing. The IENs go further and talk about feeling intimidated by the challenges associated with communication when first adapting to the local context. The peers/mentors reinforce that once IENs are more confident in their language and communication skills, they are more relaxed, more open and interact more freely with their colleagues. As a result, they are able to engage in casual conversation or chatter and they “get” the jokes and humour. Socializing with work colleagues is then much more appealing and less anxiety producing. The managers/directors add that an IEN who is integrated in the workplace is able to communicate sensitively and diplomatically when trying to get ideas across to others, especially in the context of trying to propose changes or influence decisions.

Building on the points above about the cultural dimension to language and communication skills, all of the sub-cases or participant groups describe how an IEN who is integrated in the workplace is also one who is familiar and comfortable with the cultural diversity that exists amongst patients and colleagues. The managers/directors, along with the peers/mentors, focus on how a greater cultural awareness and familiarity translates into more interaction and dialogue with colleagues. IENs can then appreciate the diverse backgrounds and skills that colleagues come with and there is a greater understanding of the team culture. Additionally, there is more ease in forming relationships with various colleagues, including ways of giving and receiving feedback as well as dealing with conflictual situations.

The senior managers as well as the IENs both explain that the Toronto context introduces a degree of diversity in the patients and work teams which is probably unmatched by any other environment that IENs would have worked in previously. This diversity along with the case

organization's values, require IENs to be highly sensitive, non-judgemental, and respectful of others, regardless of their socioeconomic status, gender, race, religion, sexual orientation, and cognitive or physical abilities. For IENs who have progressed beyond the transition phase and are now integrated in the workplace, this exposure to diversity has resulted in openness to others' values, being clear about their own cultural beliefs and, perhaps where appropriate, refining some of their own values.

As conveyed in the following quote by a manager, the IEN who is integrated in the workplace is highly aware of cultural differences even though s/he may not necessarily understand what the differences might mean:

...the IENs is understanding, "I may not understand what human dignity means in a certain culture but I do understand that it could very well mean something different than what I understand it to be". So it's just having that simple awareness. Which is not simple; which is actually quite complex (participant L026).

Feeling supported by others and being part of the team was described by all four of the sub-cases as an important way of describing an IEN who is integrated in the workplace. IENs and managers/directors explain that one aspect of getting along and "fitting in" is when the IEN feels like everyone else or as described by one IEN, feeling "Canadian" and not really thinking about how it was "back home" as much anymore. Managers/directors place emphasis on how the fact that the IEN was educated outside of Canada is not as relevant as they get integrated: "For me, what's important is that they reach a point where... they become professionals with international experience as opposed to internationally educated professionals" (participant L005). Socializing with colleagues at work and outside the workplace is highlighted by the IENs as a sign of getting along and "fitting in" with the team. It is reiterated that this notion of getting along and fitting is subjective and needs to be assessed by the IEN her/himself, and perhaps also by their peers.

IENs acknowledge that IENs themselves may not appreciate being singled out or profiled as being educated abroad when they are newly hired, or while still transitioning into the Canadian workforce. As they become more familiar and comfortable, however, their confidence is higher, they are less concerned about their practice, and they are even proud of identifying themselves as IENs to others in the workplace:

They know me as an internationally educated nurse ever since I started in the unit. And it's always been that way. But I don't know about the middle hired nurses, maybe didn't want to be associated, to be as an internationally educated. But I see that as an accomplishment that I'm here, that's my background and I'm proud of it (participant I015).

Aside from the IEN's own confidence and sense of accomplishment, IENs explain how respect and acceptance by peers contribute to the sense of pride even if it develops over a prolonged period of time:

Personally, there's a lot of pride in being an IEN and being able to say that you are respected by your peers. And that what you bring into the workplace is acknowledged as an asset...but this took a long time (participant I027).

The comfort and even pride in identifying oneself as an IEN even after several years of being integrated is stated with some surprise by one senior manager:

These nurses stepped up and identified themselves as IENs, they were comfortable to do that, even though some of them have been here 10, 12 years, you know...so I think that's a mark of success that they're comfortable to say, I'm an IEN but I'm also an integrated nurse at St. Michael's Hospital. You know, you can be both (participant L018).

The senior managers and IENs agree that workplace integration is when the IEN is happy at work, when there is a sense of belonging and satisfaction in her/his professional capacity. IENs express gratitude and a desire to stay with the organization over the long term. An IEN participant puts it as: "...there is a bigger chance of them staying within the workplace where they are because there's one thing about the people, nurses especially, who come from other countries, there's a gratitude for being given an opportunity to grow" (participant I027).

The theme of ‘being a Canadian nurse with international experience’ emerges strongly in the analysis across all of the sub-cases or participant groups. There is some recognition that the increasing diversity amongst patients and healthcare personnel is forcing the question of “what is Canadian”? The country where the IENs obtained their basic nursing education is implied to be less relevant and their international experience is acknowledged. At the same time, there are numerous references to the challenges that IENs encounter in learning how to fit in during the earlier transition phase. This disproportionate emphasis on the IENs’ transformation seems to align with Lukes’s (2005) description of the overt dimension of his power theory, whereby IENs have to change/adjust on various fronts in order to participate.

5.2.2 Progressing on leadership journey.

Assuming additional responsibilities that require advanced clinical expertise and leadership capabilities is another way of thinking about workplace integration of IENs, according to all sub-cases or participant groups. IENs and managers/directors provide examples of leadership roles such as team leading or being the charge nurse on shift, getting involved with hospital-wide special projects, including being designated as “super user” for trials of new equipment or software, clinical fellowships, and demonstration or pilot projects. IENs describe the development that results from the various leadership roles as part of workplace integration.

Responsibility as a mentor or preceptor to students and newly hired staff is another common involvement highlighted by all sub-cases. The senior managers and the IENs talk about these as “giving back” to others, to the organization, and in the case of involvement with the professional association and union, giving back to nursing:

Because I find if the IEN decides to get engaged and to develop the skills and to pursue dreams, they’re not doing it for their own selfish benefits, they’re doing it because they’re nurses who are dedicated to their profession. And they want to advance themselves but advancing nursing profession as a whole (participant I027).

Senior managers highlight that in the past, IENs have stepped forward to participate in the IEP mentoring initiative and more recently, there has been an enthusiastic response again when a senior leader invited IENs to accompany her to the first conference for IENs

An understanding of the broader nursing community and the roles and responsibilities of its various institutions is described by the IENs as something one should expect from those who are integrated in the workplace. The senior managers add that understanding the Canadian healthcare system and appreciating how it impacts the workplace organization is what is expected of an IEN who is integrated in the workplace. Peer/mentors and the managers/directors did not address this sub-theme.

Peers/mentors emphasize how all nurses have available to them, numerous opportunities to get involved in projects, committees and professional development. Managers/directors reiterate that the IEN who is integrated in the workplace is one who is committed to lifelong learning. Senior managers highlight the importance of self-advocacy as a skill, especially for the purpose of pursuing professional aspirations, both within the workplace or externally.

All of the sub-cases or groups of participants refer to how getting involved in initiatives to influence organizational policies and nursing practice is what can be expected of an IEN who is integrated in the workplace. IENs describe how bringing practice issues or concerns to their manager or the nurse educator on the unit is a common way of initiating dialogue. An open and participative management style on the unit allows for the engagement of the team members in considering possible alternatives or changes. Peers/mentors highlight how IENs can serve as role models while working alongside their peers and influence others in a practical sense:

Most of them are very passionate...for example, the family of the patient is very, what we call not demanding, but very anxious and frequently calling or something like that. But I see most of the time, the internationally educated nurses are very patient to engage

into that care... to find the solution or to work alongside with the patient and the family to tackle the issue...and compared to the Canadian educated nurse, I'm not saying that like education here is bad or something, you can see a difference. Like some take the situation in a different way but internationally educated nurses, they don't see that way...they see it's a chance to make things better, they see a chance to improve care (participant P010).

Managers/directors focus on the importance of language proficiency and the confidence in communicating in English as a pre-requisite to influencing others. The group also highlights the importance for IENs to understand the process and culture required to bring about change in the workplace: "There are some opportunities for people to take part. But in order to take part, they need to understand ... what that process looks like, that you can't just walk in and say something and immediately change happens" (participant L005).

Managers/directors reflect on the steep learning curve experienced by IENs during the early transition phase when they are adjusting to Canadian nursing practice and the local workplace environment. One manager refers to this as "soaking up like a sponge" and then when integrated, the IEN is able to "squeeze the sponge" and share with or contribute to others' learning (participant L005). The senior managers explain how IENs can help expose their colleagues to different ways of thinking about health and illness, and that the prevailing Canadian way may not be the right or only way:

I think our IENs help us to be empathetic that there are other ways, not just the Canadian way of looking at treatment and...death, and even care of the body after, all of these things... I think, when I talk to IENs about these things, I become very sensitive to the fact that what you know is just what you know, it doesn't mean it's right (participant L018).

The theme of progressing on a leadership journey, where the IEN is described like a "sponge squeezing" to let out or share her/his knowledge with others, is a powerful metaphor and resonates with what other sub-cases or participants say about the benefits of having IENs and a diverse nursing workforce. A power analysis could reveal various interpretations of this

metaphor. One could infer that when integrated, IENs have acquired more education and understanding to become empowered to influence their work environment. Another interpretation could imply that when integrated, IENs have subconsciously (or consciously) embraced the dominant ways as the desired approach. This way they are able to meet others' expectations and progress on their leadership journey.

5.2.3 Perseverance in overcoming challenges.

In describing what is meant by workplace integration of IENs, the four sub-cases or groups of participants sometimes juxtapose the ideal achievements of an integrated IEN with the real barriers they experience. The common barriers highlighted are: being judged according to English proficiency and cultural norms of self-advocacy; personal and/or family commitments; lack of preparedness of the workplace environment to be influenced by IENs, and the overall resilience demonstrated by IENs. This theme denotes that it is not uncommon for “integrated” IENs to continue to persevere with these challenges well beyond the period of transition into the workplace.

Several IENs describe how colleagues can be quick to make judgements when IENs are perceived to lack proficiency in English. Depending on the prior exposure and opportunities to learn English, it can be a long, intense and stressful barrier for IENs to overcome. One of the manager/director participants goes further by referring to how language proficiency is an important factor in IENs being viewed by their colleagues as competent:

Because it's one thing to be able to speak English but it's another thing to get your point across in a way that's clear and that doesn't, you know, perpetuate stereotypes of an internationally educated person being not so educated. Right...because it all comes down to their ability to express themselves in a clear manner. So that to me is part of the integration process (participant L005).

Another manager/director participant refers to “survival” in the workplace and is sympathetic about how the intersection between language proficiency, educational status and race may create situations that feel unjust to the IEN:

I can't imagine what it must be like to have to relocate in different parts of Ontario or Canada for that matter, when you are a visible minority...and at the same time, you're a professional...like I don't know what that must be like for people...I really believe that anybody that comes into, to a healthcare role, nursing is our example, they want to be accepted because it's so largely based on communication and if you don't feel accepted, then you're not going to survive it (participant L006).

The value of and commitment to ongoing learning was emphasized by all of the sub-cases or participant groups. Yet some IENs are perceived as not being forthright or pro-active in pursuing educational and professional development opportunities. Peers/mentors, managers/directors as well as senior leaders explain that IENs could be from cultures where they need permission for advocating for themselves:

You cannot only rely on the system itself...you need to be more proactive about your own learning and your own personal improvement...You have to know your needs to be able to integrate better. So if you have difficulty communicating, there's always English classes that you can take...sometimes IENs are not aggressive enough to take the opportunity and get themselves into something (participant P002).

IENs agree that promoting oneself is not as comfortable because it has not been how they were socialized in their country. One IEN explains:

Where I come from, you have a job, you're a nurse, you do your job and you do the same job forever and there's not a lot of movement. Nurses are not necessarily considered leaders, they're not necessarily ... And so you bring that with you here (participant I027).

Peers/mentors note that as a result, colleagues may not feel the presence of their IEN colleagues as much. They explain the challenge of how colleagues could interpret the IEN's non-participation in development opportunities as a lack of openness to self-improvement.

Peers/mentors identify personal or family circumstances as potential barriers for some IENs to get involved in educational activities or committee work. Aside from childcare and other

in-home responsibilities, the need to juggle multiple jobs in order to generate enough income to support extended family members, including those off-shore, are barriers for some IENs: “I’ve done like a lot of courses already prior...I wanted to take the bachelors here but I got married and then I’m supporting, like my parents...I had to bring them here too, I sponsored them” (participant I008). Even though there may not be an out-of-pocket expense for pursuing courses or workshop offerings, being available to attend, especially during her/his days off is identified as a barrier at times. One peer/mentor explains: “I get to talk to some...and I say that, you know... there is a workshop and it’s free...but they have to use their days off, so that’s another hindrance too for IENs” (participant P002). Various situations at the personal level prevent IENs from pursuing their aspirations. One IEN explains concretely, her hesitation in using any vacation days for professional development:

I want to save my vacation to go back to China, which is a long way and you want to save all your, maybe the whole year’s vacation. But if I want to also learn and if I was asked to use my vacation time, then...I will probably kind of resist to think about...do I really want to use my vacation time?... I may not be able to go (participant I022).

Similarly, peers/mentors indicate that committee meeting times to develop policies or discuss changes are often problematic due to work schedules, preventing IENs from participating, especially if IENs have commitments during their days off.

Taking on leadership roles and being seen as an expert resource is highlighted by all sub-cases or participant groups as one of the dimensions of IENs’ workplace integration. While there are many examples of support for the IEN to take on additional and senior responsibilities, there are concerns about how what might be seen as senior or leadership roles by some, could actually be suppressing the IEN’s development. For example, one IEN participant describes how she is such a valuable resource to her unit that she is not able to get the scheduling accommodation she requires for pursuing her educational goals:

...I don't know why they don't give the other staff other skills so they can do telemetry...special skills...and then they can free up the other senior staff. Because I find I'm always either in the [name of unit withheld] or I'm in the charge nurse role that ...no one can work on those areas...I was thinking maybe that's why they're not supporting me in my schedule if I go back to school (participant I015).

It is also not clear as to how open others are in terms of having IENs actually share or speak about their knowledge, especially from their international experiences. For example, one manager suggests that when the IEN is reflecting a lot about “how it was back home”, this may be a sign of someone who is not as well integrated. Another manager explains how for IENs to bring forward ideas, it is important they learn “diplomatic or strategic” English and only present them in the context of “quality improvement” if they want to be heard (participant L005). One peer talked about how an IEN brought up suggestions about how to do things differently at a meeting and then only in a private conversation, disclosed that that was how they did things “back home” (participant P016). While IENs bring their own expertise and experience forward, when the work environment is not open to being influenced, they risk being labelled as **not** being integrated – so when participants describe “integration”, is it possible that they really mean assimilation?

Despite the various challenges that have to be overcome, IEN participants reflect on their workplace integration experiences in a matter-of-fact way. Given that all of the IENs interviewed in this research have been working in Canada for at least five years, one participant comments about the resilience required in “surviving” the several stages beforehand:

...If you think about it, this research, after five years of working, you have to be resilient...You have survived before the five years and then the five years... there's still a lot of energy and things because it's a lot of processes to go through... you just build on it. Just build on it [participant I027].

Another IEN participant describes how dealing with and managing workplace related stress has made her more resilient: “I’ve become kind of resilient, yeah, two harsh transitions inside of Canada, it’s two different transitions...yes I would say, I find myself experienced in transitions” [participant I023]. Having migrated and coped with multiple priorities during their settlement as newcomers is described to amaze colleagues but “normal” to IENs:

...And there’s this understanding, that it’s just normal to do that. If you talk to the IENs who have gotten their licenses and working, and looking after family, going to school, myself included.... And people say, “wow, that’s so great”. And you’re like, no, not really, it is and it’s just normal, this is what you do to survive... because if you immigrate, if you do all these things, it builds your personality ...The immigration process and the changes and integrating yourself within a society as a whole and then within the workplace, is what builds your resilience, your personality [participant I027].

The theme of perseverance in overcoming challenges speaks to the resilience that IENs require and that they keep building upon as they go through the process of becoming integrated. Embedded in this theme are also the various ways in which power imbalances are exerted, whereby IENs have to conform to others’ expectations or risk exclusion.

5.3 Summary

The findings related to defining workplace integration of IENs focus on individual achievements of the IEN. They paint a picture of what is expected of an IEN who is considered to be integrated in the workplace.

While workplace integration of IENs is described as a set of achievements or outcomes, it is also described as a process on the part of both the individual as well as the organization. The focus on the organization is more evident in the next chapter where the emphasis is to understand what factors in the workplace environment facilitate the integration of IENs.

The major themes relating to how sub-cases think of workplace integration of IENs align with the review of the literature and can be linked to the four domains of IENs' achievements described in the conceptual framework, specifically to what are labelled as the social, cultural, political and economic domains of the IENs nursing work life.

Given the nature of the instrumental case study methodology used for this research, the findings in this section convey what sub-cases describe as typical and ideal notions of what an integrated IEN is. Since the sub-cases are all from the same organization, they are informed by their experiences with this employer, albeit, both positive and negative. In other words, the findings stem from what integrated IENs are or can be at the case organization, based on some of the challenges and barriers that are at play. What emerges is a "tall order" for IENs to become integrated in the workplace. From a CST and an equity lens, one question that arises is: are Canadian educated nurses subject to the same expectations of workplace integration as IENs? This is addressed in chapter 7.

Chapter 6 - Results Part II: Organizational Factors in Workplace Integration

This chapter reports on findings about how the organizational context influences the workplace integration of IENs. Perspectives on the factors that facilitate, or conversely, hinder workplace integration of IENs, form the basis of this chapter. The findings are presented at two levels: the first is within sub-case analysis where the purpose is to understand organizational facilitators of workplace integration of IENs according to each of the four sub-cases or participant groups. The second level is across sub-case analysis to gain further insights from comparing perspectives of the sub-cases or participant groups.

In response to questions about the organizational context, the sub-cases have much to say given that on average, the IENs have worked at the case organization for 9.7 years and the other participants for an average of 16.7 years. The level of awareness and insights about various organizational factors reflect the diversity in the sub-cases' roles and their respective vantage points. Not surprisingly, some of the perspectives of the sub-cases emerge from challenges or barriers experienced at the case organization. Findings that describe the challenges or barriers are shared as continuous works in progress case organization itself, from which lessons can be derived for others.

Relating back to the conceptual framework guiding this research, the focus of this chapter is on the context, processes and achievements within the workplace as highlighted in the centre and right side of Figure 9. The conceptual framework makes references to the organization's efforts and achievements in creating inclusive practices and a valuing culture that facilitates the workplace integration of IENs. After having reviewed the findings from the perspective of within sub-case and across sub-case analyses, this chapter concludes with how the understanding gained from this research relates to the organizational dimensions of the conceptual framework.



Figure 9 Workplace Integration of Internationally Educated Nurses

6.1 Within Sub-case Analysis

The purpose of the within sub-case analysis is to understand the perspectives of the four sub-cases or participant groups (IENs, peers/mentors, managers/directors and senior leaders) on how the workplace organization context or environment influences integration of IENs. In other words, what it is about the organization in terms of its culture, policies or specific efforts that hinders or facilitates workplace integration of IENs. Major themes and sub-themes about organizational factors that influence workplace integration of IENs are grouped under each of the sub-cases and summarized in Table 7.

Table 7 *Within Sub-case Analysis: Summary of Themes – Organizational Factors in Workplace Integration of IENs*

Sub-cases (Groups of Participants)	Major themes and sub-themes
6.1.1 IENs	6.1.1.1 Recruitment and support for IENs -Diverse and supportive team culture -Peers of similar cultural and linguistic background - IEN specific initiatives – communication, mentoring, research -Valuing of IEN’s cultural knowledge and language skills - Recognition of/awards for workplace organization externally
	6.1.1.2 Ongoing professional development -Encouragement from managers/leaders -Career guidance, including support to explore different roles/areas
	6.1.1.3 Policy and practical support -Organization vision, mission and values -Dealing with challenging behaviours of patients
6.1.2 Peers/Mentors	6.1.2.1 Culture of learning/teaching -Senior level commitment -Accommodations and other supports for orientation/learning needs
	6.1.2.2 Welcoming & diverse teams -Valuing what IENs bring, celebrating different cultures -Encouragement to get on committees/different roles by managers -Sensitive mentors and mentoring
6.1.3 Managers/Directors	6.1.3.1 Organizational commitment -Mission/values permeate all areas -Senior leaders championing the cause through priority setting -HR’s critical role in recruitment of IENs/IEPs -Mentoring, initial/ongoing support, draw out IEN’s strengths
	6.1.3.2 Two-way integration -Focusing on what IENs bring, not just how they fit in -Learning exchange with peers; team/peers accepting of IENs
	6.1.3.3 External community context -Influences organization’s culture and expectations re. diversity -Community engagement, attention to needs
6.1.4 Senior Managers	6.1.4.1 Strategic approach -Mission & core values of respect and acceptance -Organization-wide inclusive approach, concept of equity -Sustain focus by embedding priority, concrete plan & resources
	6.1.4.2 External recognition and initiatives leveraged -Receiving awards, invitations for involvement in expert roles -Participate in system-level initiatives
	6.1.4.3 Sense of responsibility to IENs/staff -Organizational commitment to invest in/support staff -Dialogue/support at individual level for achievement of professional goals

6.1.1 IENs' perspectives on organizational factors.

The organizational context which is most conducive to workplace integration is described by IENs as one where staff members are from diverse backgrounds, where concerns are heard and attended to at the individual level, and where there is an ongoing learning exchange between team members and through formal professional development. Just as how the diverse and marginalized patients have to be treated with the respect and dignity, the case organization's mission and values are also acknowledged as important underpinnings for the valuing of what IENs bring to the workplace. The sections below elaborate further on how IENs speak about each theme.

6.1.1.1 Recruitment and support for IENs.

The theme of recruitment and support for IENs addresses the positive effects of diverse teams and the need for specific provisions for IENs to be able to integrate in the workplace effectively. The organization's commitment to and the actual recruitment of IENs is emphasized to begin with: "I'm a big advocate of hiring more nurses that come from other countries" (participant I027). IENs speak about the early challenges in finding employment and how having been given a chance by the case organization was an important breakthrough: "When I started to look for a job...they always ask for Canadian experience. Like it's so depressing at first...well, they give me a chance...this is the hospital who gave me the chance to practice" (participant I011). The case organization's commitment to IENs and Canadian educated nurses from diverse backgrounds has been noticed by IENs: "Because when I started at St. Mike's, there weren't many internationally graduated nurses but now, every floor is like dominated with every nationality background" (participant I014).

The feeling of “not being alone”, in terms of diversity of backgrounds and having other IENs on the team, is described by the IENs as a key factor in how the context enables workplace integration:

So we’re really like a multicultural unit...I like it, because again, it’s like we learn things from each other and you know, it’s great because we’ve got a nurse who speaks Mandarin, one who speaks Cantonese, one speaks Vietnamese, one speaks Korean. Like, three of them speak Portuguese. So it’s great, we have people who can help each other out and like it’s really quite fun (participant I001).

Some reflect on how workforce diversity was important right from the early days of getting introduced to the Ontario setting:

...the person who was orientating me was a Filipino nurse and the other person who was orientating me on evening was also a Filipino nurse. So I really felt that they supported me in the things that I want to know. They would encourage me to ask questions, if I don’t feel that I get it...I was lucky actually, I was blessed...there’s senior staff on that floor and they made me join them during like lunch breaks...our manager was Italian...and my other unit leader was of an African descent...she made me feel welcome (participant I008).

The diversity in the employees is not just from IENs being recruited, but also Canadian educated nurses of diverse heritages: “I’m noticing there’s a lot more, not just IENs but like nurses from different cultures working...first or second generation Canadians and they do nursing and they start working...the environment is changing to adapt to these new nurses, this new culture” (participant I012). To some, there are perceptions of added support when IENs are with other nurses from a cultural and language background similar to their own:

This hospital, it’s good with being multicultural, but still, if you have a company [peer] from your background, you’ll get more help. Sometimes, you know, not all the people help each other, right, we need the teamwork...if you have [only] yourself [from a different country] in one unit...you will feel lonely I think... (participant I020).

The IENs recognize that the organizational policy (Dress and Department) emphasizes English as the common language of the workplace and that this is necessary to foster teamwork and sensitivity to patients and their families:

We receive memos from previous managers that we're not supposed to speak our own language especially when there is someone who don't understand our language, especially our colleague in particular, in front of the patient...I myself sometimes I correct those like agency people...clinical assistant, they're talking in our language in front of the patient who does not speak Tagalog, I myself cut them off... (participant I014).

Conversely, being the only IEN on a unit or team can have its benefits too, according to one of the participants: "if anything that I'm an IEN was emphasized within my service, like where I work...there's not a lot of IENs and that might be why I got these opportunities that, because there's no large number" (participant I027).

With respect to specific initiatives to facilitating the integration of IENs, some of the IEN participants recall the IEP Mentoring project they had been involved in either as a mentee or a mentor. Taking part in the IEP Mentoring project was described as a positive experience. The opportunity to network and connect with other IENs/IEPs at the case organization was highlighted as a key benefit:

So a few years ago, there was an initiative that included mentorship and mentee program for IEPs...I got an invitation to participate in the program and as a mentor, not a mentee...Actually, my mentee still works at St. Mike's as well, she's an RN...I thought that was great...it was not just nursing, it was professionals across the board (participant I027).

Most of the IENs working in the case organization have not had the experience of being part of any specific initiative designed for their needs: "I mean, orientation was just very general...it was within the unit but there wasn't any kind of service or anything that they offered me that was for international nurses" (participant I001). Some raise the issue of how important it is not to feel singled out but at the same having their specific needs addressed, especially during the orientation and transition phases: "Being buddied with someone in the unit who worked there for three months...it's like trying to help nurses feel comfortable in their new workplace area, in all aspects" (participant I017).

A focus on communication and language skills for IENs is also highlighted as helpful, especially for those who are still in their early transition: “I think they have a CARE program. They ask the teacher...from CARE program to come to our hospital to teach English...help learn correct pronunciations” (participant I021). The case organization’s active role in serving as a placement milieu for IENs in bridge training programs was described as an additional way in which early transition into nursing is facilitated. While these pre-employment initiatives do not result in all of the IENs themselves getting hired at the case organization, they highlight these as different ways in which the employees are exposed to IENs and to their employer’s commitment to IENs’ success.

When the case organization is recognized externally for its efforts with IENs, it has an indirect but helpful effect on integration in the workplace: “We were chosen as one of the designated hospitals for internationally trained nurses...we were recognized by the government for the effort for the program that we’re giving to, to international nurses” (participant I017). IEN participants notice when senior managers take specific actions to highlight IENs in a positive light:

[The senior manager] decided to sponsor one student, one nurse per unit for this conference by CARE...other than that, in my seven years, this is like basically the first thing that I’m specifically attending for the IENs. When my manager asked me if I’ll be interested, I said, yeah, I would love to attend because I was part of the CARE group before (participant I008).

Initiatives aimed at IENs at different levels in the organization, including allowing this IEN related research study, are considered to facilitate workplace integration:

Well, to me our hospital is paying more attention to IENs now and it’s...even our head nurse is involved in this... I’m happy... Maybe I wasn’t paying too much attention...any specific things offered by St. Michael’s to IENs? Now...I’m very happy to, to have you [PhD candidate] here...doing research on IENs...that’ll create more awareness (participant I022).

The valuing of IENs' cultural knowledge and language skills by other colleagues on the healthcare and nursing teams is perceived as another key facilitator by IENs:

We are a big floor, we have like 16 nurses [working] during the day on the floor, and we want the nurses to speak different languages because we have all kinds of patients who need translation. You can get translation right away. You just grab your colleague, come, I don't know what the patient wants, I don't understand, yeah. That is really good, a really really good resource and benefit (participant I022).

In addition to contributing to their colleague's understanding of cultural matters relating to patient care, the role of IENs in saving time and costs of interpreters are highlighted as well:

When I was [working] in the clinic, I was being used like as an interpreter many many many times. And the doctors and the nurses, they were really very appreciative because it saves patient's time, save doctor's time and it just helps with the flow of the clinic (participant I022).

The case organization's caring and celebratory culture is noticed by IENs: "St. Mike's particularly, I feel like they're pretty good at sort of recognizing and celebrating their staff which makes everybody feel valued, like not just the international nurses, everybody" (participant I001). Each year, the process of nominating and selecting winners of the case organization's Mission and Values awards is a powerful way for the individuals who are being recognized: "After the fellowship and with my involvement with IEP, I got one of the mission and values award...Pride of Achievement award" (participant I027).

In summary, this theme highlights the value that IENs place on the case organization's commitment to a diverse nursing workforce. They acknowledge organizational commitment which extends beyond hiring of IENs, to provision of customized supports which are responsive to the diverse staff's orientation and development needs, including specific strategies to promote a sense of community and belonging. These possibilities of connection and camaraderie amongst IENs can facilitate the sharing of concerns and strategies to overcome challenges arising from power struggles or imbalances.

6.1.1.2 Ongoing professional development.

The theme of ongoing professional development addresses the availability and access to a range of educational initiatives made possible by the organization and specifically through the encouragement from nurse managers. The opportunities to participate in professional development workshops or courses are highlighted by IENs as important in order for them to effectively integrate in the workplace:

But we are supported in a way that if you want to take educational leaves... there's also courses being held in-house at St. Mike's, so you can just register online and attend those courses if you're interested and there's a lot. It [topics] varies from diversity to management, to conflict resolution or other aspects (participant I008).

Professional development is valued by IENs and there are numerous options: "There's no limit at St. Mike's, they offer a whole lot of opportunities...it is just up to us IENs, if you want to pursue something else other than a staff nurse" (participant I015). Aside from the one to two day workshops or conferences, some give examples of longer term and more involved pursuits to explore new clinical areas or roles:

There was a nursing internship training that St. Mike's was providing. So I applied for that. So it means that you can check out other units for three months... I also took advantage of some support from the hospital and also from the RNAO...to upgrade my critical care skills (participant I017).

Encouragement and support for the individual IEN's growth are major factors in feeling more integrated and satisfied with the workplace organization:

I feel integrated and personally I stayed with St. Michael's because there's been ongoing support for my growth, if I chose to do that. It's a matter of my personal choice but it would be difficult if I wanted to do something and I'm not given an opportunity. That for me would be a problem (participant I027).

IENs speak about the vital role of frontline managers in feeling supported: "all my life, I would be very grateful for her [manager] support. That's what probably held me together in my hardest times" (participant I023). Managers' openness and approachability are noted as key by

another IEN participant: “The managers have to be very supportive and be confident in their staff, IEN staff...if I have managers who are willing to listen, and not very critical, then I’m not afraid, then I can say anything, make any suggestions” (participant I022). Managers taking the time to draw the IEN’s attention to opportunities on the unit or to encourage involvement with different initiatives around the organization, are viewed by others as an important factor in facilitating integration: “For the improvements of our units...they ask for our ideas...there are regular meetings organized by our manager, our nurse educator... they welcome opinions, suggestions...I think they ask everyone to get involved” (participant I011).

To summarize, this theme highlights that opportunities for IENs’ career growth and advancement are not limited to the availability of professional development activities. Various barriers to accessing professional development may be encountered, and so a participatory leadership style among managers that engages IENs is an important factor in facilitating their involvement, leading to integration in the workplace.

6.1.1.3 Policy and practical support.

The theme of policy and practical support addresses how the organization’s mission and values affect the workplace culture, and the implementation of specific policies and practices relevant to IENs’ integration in the workplace. The case organization’s vision, mission and values, along with its historical roots are described as basic building blocks for creating a diverse and supportive internal culture, as well as for IENs to check for alignment with their own values:

The values that St. Mike’s has are the same values that you [IENs] have. I think that’s part of integration, that’s why you’re here. That’s why you took this opportunity to work for a certain organization. I think that’s part of integration (participant I015).

The importance of the congruence between the case organization’s vision, mission, values and the hospital’s commitment to a diverse workforce is articulated by this IEN participant:

St. Mike's [mission] is that we work with the very marginalized population, very diverse and very challenging. And to do the best job, you have to have a diverse workforce. And what's a better way than to have diversity in your nursing (participant I027).

While all of the IEN participants are humbled by the case organization's mission to serve the most diverse and marginalized patient population, they acknowledge that this adds significant challenges to an already stressful nursing role. IENs reflect on hurtful situations when they were subjected to abuse such as racist remarks or outright rejection from patients and/or their families. The IENs are grateful for the policies that are in place about managing violence in the workplace and the supportive actions of their peers and managers:

Sometimes they [patients] really use some bad words to us...but luckily we have other staff, they help us to talk to the patient and to...maybe it's not proper to say they fight back for us...they will help us...first thing, they take over from us, we don't take care of that patient...when they talk to them, they sometimes warn them, "if you do it again, we'll call the security"... and then sometimes we really call the security ...let the manager come and get involved to talk to the patient...and then sometimes we ask the doctor to get involved too...(participant I021).

Pro-active interventions from the broader inter-disciplinary team, including chaplaincy are also seen as supportive:

We have a spiritual leader...chaplain...she does not only take care of the patients, but she also looks after us...always checks on us, if we're okay, like if we need anything...if something happens in our unit, she debriefs with us and occasionally she would have a session for relaxation... (participant I008).

Building on the organizational mission and values, a range of specific policies and practical supports which promote equity are emphasized. From hiring IENs and a diverse workforce, to appropriate orientation, mentoring and professional and skills development, to the valuing and recognition of their linguistic, cultural and clinical expertise – are to IENs' workplace integration. Sensitive and active support from managers and colleagues is critical to IENs, especially in relation to discriminatory and upsetting behaviours of patients/families.

6.1.2 Peers/mentors' views on organizational factors.

Aside from a culture of openness and acceptance of diversity, which is linked back to the organization's mission and values, the peers/mentors provide concrete examples of how IENs are supported in their learning and adjustment in the early phase of transitioning, which they then attribute to effective integration in the workplace in the longer term.

6.1.2.1 Culture of learning/teaching.

The theme of culture of learning/teaching outlines how the broader organizational context as a teaching facility can be conducive to flexible and accommodating approaches to suit various learners, including IENs. Peers/mentors describe how the case organization's role as a teaching facility is aligned with the focus on diversity, as there are numerous learners at all levels and from diverse backgrounds: "Our mission kind of values everybody...rallies everyone as individuals" (participant M004). The culture of teaching and learning for students and professionals of all disciplines makes the link to supporting IENs natural: "The environment, starting from the culture of where we work ... St. Mike's is a teaching hospital, it's a teaching facility and very open to the building process for anyone" (participant P010). The active part played by senior leaders in fostering this culture is noted as another factor facilitating IENs' integration by one peer/mentor:

She's [senior leader] a central part of it...the interesting aspect that I find with her is that she attends as much as possible every single nursing orientation...she comes and brings, you know, welcoming remarks...which is really quite remarkable for someone in her role...from my experience where I've been, that doesn't happen all the time (participant M007).

Peers/mentors point to the commitment of senior executives towards inclusion of IENs/IEPs, and all staff in general, as important in facilitating workplace integration. This is noticed and taken as a cue by other managers and staff at different levels in the organization:

And I see how our [senior leader] ..., she's very supportive with the internationally educated nurse. And we also, we staff member also open to them [IENs] and welcome them in a very friendly environment...And that makes such a difference for them and they feel so welcome and supported (participant P010).

Peers/mentors are typically working alongside IENs but are also involved with orientation and mentoring types of activities. Two of them are formally in the role of nurse educators on their units. They describe basic approaches for early orientation:

I think setting them [IENs] up successfully with a clear learning plan, so you know, what are your goals, what do you want to learn, this is what we need and being very very clear with that...I think where I've seen staff not do well...it hasn't been...clear...we've assumed (participant M007).

Demonstrating flexibility with the length of orientation to respond to specific needs is important for some IENs:

She [IEN] was buddied up with another nurse... her six weeks training was over, and then they put her on her own...She was a little nervous, you know. You know how some people don't get the full confidence to be by themselves? The problem was, she always liked nightshift...there used to be issues...she was too shy to say she needed more time...then the manager did give her more time...she's one of our best nurses on the floor... So you know, we have to also give her the leeway, we have to spend the time, buddy her up again and make her feel comfortable (participant M004).

Responding to specific learning needs also requires being sensitive to the IEN's requirements and setting her/him up for success:

We had a nurse from India...She was hired for one of the critical care units but they [her unit managers] ...sent her to our floor for a month, just to get her baseline, you know, just to get familiar with...Canadian nursing...They sent her to get trained on our floor for a month, which is general internal medicine, you get everybody there...So to me, that is great. You know, you just don't hire them [IENs] and then make them work in the critical care area...So that made the nurse feel very comfortable...when she was done a month... (participant M004).

To summarize, peers/mentors highlight how the organization's culture of promoting effective learning and teaching for its diverse learners is an important factor in IENs' workplace integration. Examples are provided to reflect that the onus is not only on the IEN to learn but

also on the organization to acknowledge the diverse realities and the need for differential supports from an equity perspective. Utilization of appropriate teaching methods and to continually improve or adjust as needed is emphasized.

6.1.2.2 Welcoming and diverse teams.

The theme of welcoming and diverse teams addresses valuing what IENs bring to the Canadian workplace. It includes encouraging involvement on committees and other roles, and the importance of sensitive mentors and mentoring for IENs in an effort to facilitate their integration in the workplace. The level of diversity in the staff and patients contributes to the open culture and facilitates workplace integration of IENs, according to this participant: “One thing that makes it unique is that it’s sort of the openness around...being very accepting and very welcoming to, you know, to staff...and certainly in particular to the patients that we see...because it is extremely multicultural” (participant M007). Accepting and supporting the IEN for who s/he is at an individual level is important to another peer/mentor: “Supporting the IEN into a new unit...I never look at them as being an IEN. I just don’t...They’re a colleague...they are just part of the unit...my peers, like they’re like my colleagues. I don’t see them any different” (participant M004). Appreciating the benefit of the cultural fit between patients and IENs adds to the team spirit as highlighted by this participant:

So we kind of work alongside, work together as a team. And like let’s say very simple example, a nurse come from certain country and the patient like comes from same country. And you can see the benefit. And they kind of know the culture more and we don’t know (participant P010).

While raising the cultural awareness and sensitivity towards IENs is important, one peer/mentor points out how the reverse is equally critical. Peers/mentors give examples of how insensitivity or lack of awareness on the part of the IENs can upset the patient and family but also have implications for the team and the organization:

It becomes really a challenge or kind of just shock if we don't have proper preparation for them [IENs] to come and then there's an issue, there's going to be a problem...Family takes it very personally... for example...like a certain way of performing ADL [activities of daily living] and the person cannot really well understand what's going on...They [family] see we are trying to change [the care for their] loved one or that we, we're doing something that's not right...Then it's going to be a big issue...goes up until a manager or even a CEO is involved, yeah. I've seen that (participant P010).

One peer/mentor notes that the case organization's hiring focus on IENs who are already on staff but underemployed as unregulated clinical assistants or in other non-nursing roles, is an encouraging and valuing sign to all IENs on the unit:

We give opportunities for everybody...even our CAs on our floor...clinical assistants...Our manager... she always looks, when she's hiring, when she's putting the job out, she will hire somebody who's a CA, a nurse from the Philippines but who's working towards her RN registration...If they're interested, she will give them the first choice of the job (participant M004).

An example of celebrating different cultures was provided: "I don't know if they're still doing that...showcasing international nurses and ...showcasing their culture. So I think that makes international nurses feel more integrated into the system" (participant P002).

Peers/mentors highlight the importance of encouragement by managers for IENs to get involved on various committees or task groups as a factor facilitating their integration in the workplace:

Well, they're posting what opportunity is there...and so everyone has equal opportunity to apply for that position. The leadership encourage nurses to get involved...makes these people feel ...they can do the job...being approached. And then saying you would be good for this role...There is a position or we have a committee, we are forming a committee and would you like to be involved? Now they're starting grand rounds, so they get nurses involved into presenting some educational topics (participant P002).

The perception that some IENs do not appear too eager to get involved on committees is explained as the IEN's lack of confidence, or feeling inferior, or perhaps due to limited communication skills:

They're [IENs] not eager...apply for a higher position in nursing. They're not as aggressive I should say as the nurses who are trained here...They have that feeling of, I don't know...oh, I might not get it...I think it's the feeling of not being good enough for that position, although they've been trained here forever, they do their work well, they've been educated more. I think it's all about communications too (participant P002).

Peers/mentors recognize that they need to be appropriate in their approach to mentoring IENs due to cultural differences: "Outside of English being a first language...I think we have to be very culturally sensitive because I think that is an aspect of supporting our nurses as well. Not every culture is maybe, I'm going to say, very verbose, right?" (participant M004). There can be differences in learning and teaching styles as well:

It can be very respectful in the fact that they don't ask questions...because...it's deemed to be very disrespectful to ask as many questions as you need to. Whereas we're in a culture of where we nurture them to say, please do ask questions (participant M007).

Assigning a buddy to each IEN was described as an effective strategy to address learning needs at an informal level as well as to make the IEN feel welcome:

We have a lot of foreign educated nurses on our floor and I know when they got hired, they got buddied up or they had a peer nurse to be with for six weeks or so... just to learn, from us what we know to pass on our knowledge and skills to them and for them to feel comfortable. Because they're in a different setting, right? When you team them up with somebody ...speak to them, they do feel comfortable ...that there is a resource person, a buddy person there for them (participant M004).

Offering specialized training for peers/mentors was also described as a helpful strategy to facilitate IENs' integration: "I was just thinking that if we have like special training or like workshop, it doesn't have to be long or even online tool...of expectation, what kind of support and what kind of assistance that we can offer" (participant P010).

Building on the culture of learning/teaching, the theme of welcoming and diverse teams also makes the connection between how the presence and involvement of IENs has a broader benefit for the rest of the team. In particular, the effects on quality of care of patients are noted.

Peers/mentors' recognition to become more effective in supporting diverse IENs is noteworthy as it highlights the notion of a shared responsibility.

6.1.3 Managers/directors' perspectives on organizational facilitators.

The organizational vision, mission and values and senior level commitment are emphasized by managers/directors as key drivers for an open, accepting environment that facilitates IENs' workplace integration. Initiatives that focus on preparing the overall organization to be a welcoming environment and specific ones with deliberate aims to support IENs and IEPs, are also highlighted. The following sections substantiate these themes using the citations from the managers/directors at the case organization.

6.1.3.1 Organizational commitment.

The theme of organizational commitment addresses how the foundation of the case organization's mission and values is logically linked to the priority of workplace integration of IENs, and that champions at the corporate level are crucial. Staying true to the organization's mandate by setting strategic priorities related to equity, diversity and inclusion, has helped in ensuring that the mission and values permeate all areas or aspects of the organization. One manager/director stresses how it has been an important factor in facilitating integration of individuals from diverse backgrounds, including IENs:

Our mission and values of the organization are very clear that we're a place for everyone to come and there's a certain, I must say that among the staff group, there's a definite lived compassion that I see on a daily basis...Those ideas of how to assist someone has been so integrated that people don't even think of it as integration. They just think of it as the norm...that to me is what feeds the culture the compassion is there, those kinds of values that relate to the mission and values of the hospital, that were developed in 1892 by the Sisters of St. Joseph, they're alive and well and still quite very strong. And they influence our daily operations (participant L005).

Building on its historical roots, the case organization operationalizes its values through deliberate priority setting. A strategic focus on IEN and IEP recruitment and integration is one such example emphasized by another manager/director:

Yes, it [recruitment and integration of IENs and IEPs] actually has been in the past where it's been part of the strategic plan. Hugely part of it... corporate goals and there's been accountabilities to it...I don't think it's in the current one...there also were champions and that it was consistent and broad (participant L026).

Managers/directors are insightful about the power and influence of senior leaders as champions for the cause of IEN integration, which allows other managers in more junior positions to follow suit and have the assurance that they will be supported for their efforts, including resources that may be required:

I think...it does start from... a higher level in the organization and by supporting programs like, the internationally educated program that's come out. Things like that I think encourage managers that it's okay and it even helps them to kind of realize there is support out there and because some managers who are fearful to kind of hire somebody who's never worked in Canada before or you know, they were trained in a completely different country and completely different culture and a different healthcare system (participant L019).

Sustaining the commitment to IEN integration amidst other priorities can be a challenge though:

Really the senior leadership commitment makes or breaks the focus and the commitment to workplace integration...I think the challenge for them is maintaining that priority in the midst of all the other priorities that they have...I think one of the take home messages that St. Mike's has learned that can be shared with others, is that commitment and the dedicated resources that keep their eye on this and keep it going...is hugely important (participant L026).

Managers/directors speak to how critical the Human Resources Department's role is in implementing the priority of recruiting IENs and implementing programs to support their transition and integration: "There was a huge HR push. They were the leaders ...and people were energized..." (participant L006). The overall make-up of the nursing team, the context and

capacity of the unit are key factors at play during the process of making recruitment decisions to fill nursing positions:

Some of them [IENs] may require more support and more training, but if you want a certain team dynamic, like for me I think having somebody who's approachable, whose lifelong learning is important, I think those characteristics are important for this type of unit. You need somebody who's willing to not be afraid to make mistakes and to, you know, acknowledge them and try to learn from them and work well within the team. That's to me the most important, you can train somebody to do a job but that's important, it doesn't matter where you come from (participant L019).

Nurse managers also highlight the importance of having the systems to provide IENs with initial and ongoing support:

When they're (HR Department) looking at applications, I know that's taken into consideration... So if you're not giving the IEN an opportunity, because they've never worked in a Canadian environment, what is that saying about St. Michael's Hospital... So they're not limited, they're very open with regards to ...who they provide the opportunities for or who they actually say okay, yes, we have the capabilities and we have the support system in place... (participant L003).

The IEP mentoring initiative implemented in the past was not exclusive to IENs, but for IEPs from various disciplines employed at the case organization. IENs/IEPs got oriented to the workplace culture in a non-threatening way and had opportunities to network with co-workers who were more experienced:

...concrete supports that are available to IENs when they walk in, when they're hired to the organization...support for internationally educated nurses in terms of helping them with their communication skills, helping them ... because some of the jargon and some of the terms that we use are not ones that they would have been familiar with in... It is not necessarily to help them with their technical skills because they already have that. But its understanding the cultural nuances within the actual workplace...as well as networking opportunities, which we know are absolutely key...and being able to have conversations about challenges that are occurring within the workplace that the experienced professional may not have had necessarily in your own country... (participant L026).

Evaluations of the organization-wide IEP mentoring initiative found it was beneficial to those who were still early in their workplace transition, as well as those who have been working for some time:

The feedback that we got at that particular time is that IENs brought a great deal and contributed to the organization. But that having been said, they clearly had some challenges integrating into the organization in terms of understanding the nuances of the culture, the communication and to some extent, patient care. And that with additional support, they actually integrated and stayed longer than if they hadn't necessarily gotten that support (participant L026).

Some managers describe how at the nursing unit level, taking the time to identify and assign the right mentor for the IEN was important. For this participant, the focus is what the IEN's learning needs are and how best to draw out her/his strengths:

I need to buddy you up with somebody, who is the best person, who am I going to buddy you up with regards to making you succeed and making you feel comfortable and making you shine or blossom or open up and we see the true potential of what you can provide (participant L003).

One manager/director participant emphasizes the value of a mentoring or buddy system for IENs, as well as all newly hired nurses, as the stakes in the relationship are different from the more common form of preceptoring found on nursing units:

A buddy system of all new nurses with long term nurses would be great...not just for IENs but everyone when they're first starting...They're supposed to be preceptored anyways...That's different than mentoring...preceptor, because they are going to have to go through a performance review...during their probationary period. Whereas I very deliberately, always have, and will continue to draw the differences for people between what is preceptoring and mentoring (participant L006).

In summary, this theme of organizational commitment to IENs makes the link to the hospital's roots and its mission and values related to diversity and inclusion. The role of senior management as champions of recruitment and retention of IENs/IEPs is highlighted as an effective signal to managers at other levels. Corporate level support can result in the design of relevant initiatives, including cultivating a team culture conducive to workplace integration of IENs.

6.1.3.2 Two-way integration.

The theme of two-way integration as introduced here by manager/directors refers to the organizational environment and the various players within it, acknowledging IENs from an asset based perspective, and thus being open and willing to accept them as valuable contributors of knowledge and expertise. The importance of shifting the focus to what IENs bring and not just on how they fit in is highlighted by this manager/director: “I think with internationally educated nurses...there’s more opportunity to educate their peers and their colleagues in terms of what IENs really bring to the workplace...not just what they have to learn but what they contribute” (participant L026). The informal learning exchange that happens between IENs and their peers in the context of patient situations is described as effective due to its immediate relevance and for learners not to feel judged – an affirming and asset based approach is emphasized for both IENs and their fellow nurses by this manager:

So I think from a nursing perspective, you can learn a lot of different things ... it heightens the quality of nursing ... when you work in these type of [diverse] teams...I think you actually, you get to understand, you know, a little bit more about different cultures and I think people are more open to it when you work with patients from different cultures...sort of an informal learning, from your coworkers... as well as patients when you kind of have a multicultural environment for ... Because I think it, it’s less judgmental, you kind of understand ... you start seeing it over and over and you hear about it over and over (participant L019).

The notion of multi-way or two-way integration is described by another manager/director as focusing on what IENs contribute to the workplace and not just what they require to integrate: “So it’s not just how they integrate into it but also how they impact it. And I think ...that really makes it a true workplace integration because it’s a multi-way fit. Does that make sense? (participant L026). Another participant describes the two-way integration as one where the peer

nurses/fellow colleagues in the workplace environment are also open and willing to embrace IENs:

And again, that's a two-way street. So the people who are within the hospital have to be ready and willing to accept someone who...may be on a learning curve in terms of culture and linguistics and practices and Canadian nursing practice (participant L005).

The net effect of how the diversity of experiences and talents of IENs enrich the organizational culture is articulated by this manager/director:

We think about the IENs fitting into the organization. But the true benefits of the internationally educated nurse, is not then just being a warm body and fitting into the organization but also what they bring to the organization, what they bring to patient care from the very fact that they are internationally educated and how they contribute and make our culture, not our culture in terms of Caucasian but I mean, our culture in terms of the organization, better (participant L026).

Two-way integration as described by managers/directors has the connotation of striving for balance in power by viewing IENs as assets as opposed to a drain on resources. The role of peers/team members' in allowing IENs to "fit in" and to be open to learning from them re-emerges.

6.1.3.3 External community context.

The theme of external community context addresses the influence of the organization's external constituents on its internal culture, and especially challenging dominant norms to become more responsive to diverse needs in diverse ways. The level of diversity in Toronto, and specifically the case organization's catchment area, provides continuous informal learning opportunities between peers. This manager/director participant speaks of how the Toronto context provides a unique opportunity for learning and appreciating diversity in people's backgrounds:

Everyone goes through cultural sensitivity training, and I think in Toronto, we have a unique perspective on all of this...because unless the person is First Nations, Inuit or Metis, chances are, they're, them or their parents or their grandparents came from

somewhere else...Over half the city wasn't born in Toronto, in Canada, right? So we're very accustomed to people on this learning curve of cultural and linguistic integration and even learning new practice, new ways of doing things, right (participant L005).

Engaging with the external community and paying attention to broader issues, such as social determinants of health, are outlined as core principles in the development of the Inner City Health Program at the case organization. An organizational context where the hospital plays an active role in supporting advocacy efforts relevant to its community while at the same time achieving its own goals, contributes to workplace integration of IENs:

It was about getting people specifically in Regent Park, jobs...because we had a significant size of low income internationally educated professionals right in our backyard...that's what it was seen like from the Inner City Health program perspective, where we were looking at the social determinants of community health. Whereas from the hospital perspective, it was seen as a way of meeting, from a corporation or a system's level thinking, it's about meeting the shortages that exist within the healthcare system (participant L005).

In summary, the profile and context of the broader external community within which the organization is situated has a bearing on the organization's culture and priorities. The organization's efforts to collaborate with the community on its priorities related to integration of immigrants send positive signals to IENs and in turn reinforces their loyalty to the workplace.

6.1.4 Senior leaders' views on organizational facilitators of workplace integration.

The senior managers outline the organization's strategic approach to ensure that the priority of workplace integration of IENs is embraced at all levels. The organizational culture and specific strategies to perpetuate the desired commitment and behaviours are highlighted. Deliberate structural initiatives and continuous championing by senior leadership are helpful. However, sustaining the focus on the priority is challenging. The external environment and system level initiatives can provide an impetus for staying on track internally.

6.1.4.1 Strategic approach.

The theme of strategic approach addresses how the organization can leverage its planning and management processes to implement the priority of workplace integration of IENs as part of its broader efforts to promote health equity. Like the other sub-cases, the senior leaders interviewed in this research relate back to the case organization's history and mission of why it was established in the first place, as the rationale for giving priority to workplace integration of IENs:

I would say that this sort of initiative [workplace integration of IENs] is sort of easy for the organization to embrace. It just fits. You know, our mission to care for anyone who comes here regardless of background, is fundamental to who we are and in fact, we give preference to the most disadvantaged...People that are having trouble integrating into our society are patient priorities for us. We're prepared to invest in them perhaps more than others might. And that really comes with our 122-year mission history. So looking at our staff in the same way is an easy one, sort of comes right out of that (participant L024).

The organization's role as a tertiary care centre and its affiliations with institutions of higher learning, are highlighted as another reason for this fit: "And as an academic hospital, it's part of our mission and reason for being, that we be open to learning and...working with new cultures, people from new cultures is all part of that" (participant L025). The hospital's founders' core values of respect and acceptance are kept central to the organizational culture and underlying philosophy, even today:

So the culture's kind of how people think and how people behave who work here...It's those people who actually sustain the culture...They're the keepers of the culture, they teach the young ones, this is how it is here... And they tell stories, great stories of things that other people have done. And so it's passed on. So that sort of accepting attitude works well for new staff and it works well for staff ... of varying backgrounds (participant L024).

Aside from the informal or organic way in which the culture is perpetuated, there is a deliberateness to discussions about values and beliefs by senior leaders and during the orientation processes at the case organization:

So when we recruit people, we talk about our core values and our mission...I think that's kind of an explicit thing we do and, and I think maybe not all organizations do that but we do believe it's fundamental to the success. Because you want people whose values align (participant L018).

The resultant effect is described as an inclusive culture:

We have a culture...that is very open and inclusive to patients, if you like... that is very acceptant of different ways of talking and different ways of being. There's a non-judgmental sort of approach to care. Almost in the extreme ...people behaving in ways that are totally objectionable and we still are welcoming and open. So if you can do that with patients, you can do that with each other, right...People are looking out for you as opposed to... judging you (participant L024).

Beyond the mission and values which underpin an inclusive culture, an organization-wide approach which stems from the senior-most leader's commitment to workplace integration of IENs is clearly acknowledged: "The CEO is an enabler obviously of the biggest kind because if they don't think it's important, it doesn't mean it won't get done but when they think it's important, it's for sure going to get done" (participant L018). The senior managers speak about the power they have in influencing others within the organization:

Strategically and philosophically as a leader, I have to see the value of our IENs to our organization and to our healthcare system. So if I don't see that, I'm not going to really invest any time or energy in that. So that's why I see my role as an executive leader to make sure that my other executive colleagues understand this is our commitment and support it and also that I'm working with directors and managers (participant L018).

But the commitment must be more than just leaders talking about the priority. It has to include taking action through the development of concrete plans, and allocation of resources for implementation: "So if you don't have the strategic discussion, it'll never be alive. But once you have strategic discussion, our job as leaders is to say, what [are] the tactics that will get us there are...that's our role" (participant L018). Various structural initiatives have been put in place at the case organization by the senior management team over time. The importance of embedding

priorities into the strategic plan at the organizational level and throughout the various corporate divisions is also emphasized:

So strategically, our nursing strategic plan really committed [us] to help human resource management for nursing... and from that nursing leadership and planning. In 2009, the hospital's strategic plan very explicitly outlined that we would be committed to having a diversified workforce and actually applying resources to be able to do that. So I think the first thing is that organizations have to make that strategic commitment and they have to think of their health human resources in the context of who they're providing services and care to (participant L018).

Another senior manager reinforces the need for the priority of IEN/IEP recruitment and integration to be embraced by the entire corporation, and the critical role of the HR department: "I think it has to be integrated corporately, not just in a few places. But I think HR is a key one" (participant L025).

The establishment of a high profile role with responsibility to promote the organization's values through a variety of activities has been an important decision:

To promote the values, we build those into our management ... I mean, we have for example, we have a Director of Mission and Values...a person whose job it is to promote [the hospital's] mission and values. She's a member of the senior management team...works directly for the CEO, has sort of access to almost anything in the hospital and is almost like an ombudsman for the staff (participant L024).

Building on the values of respect and acceptance, developing an understanding of the concept of equity across the organization was another concrete step taken by senior management: "We created a Diversity Special Projects Coordinator...that position has been there for many years...it's a visible and structural manifestation of a commitment to equity on all levels" (participant L025). The experiences at the case organization have added further insights about how in order to get the buy-in across all areas, it helps to align the focus on equity, diversity and inclusion with core priorities related to quality of care issues and to use existing structures:

There's good literature on the business case for integration, diversity, as it relates to client or patient satisfaction. And quality is the great equalizer for all organizations to be able to

say, yes, we can demonstrate that we deliver quality care for everybody. And there's legislation now that says, quality for all, care for all... by aligning with the existing structures, expectations that you could advance your case (participant L025).

Similarly, alignment of the priority of workplace integration of IENs within nursing with the broader organizational focus on IEPs is justified as more beneficial by this senior manager:

So the nursing strategy then moved into the corporate strategy and for all areas, health human resource was a priority. So I know we're talking primarily about IENs but the broader the thinking is, in other areas in terms of IEPs, the more it will enhance the IEN discussion (participant L018).

Several strategic examples of keeping workplace integration of IENs on the organizational agenda are described as part of this theme. Aligning the priority of IEN integration more broadly with the need for a diverse workforce to achieve academic excellence and delivery of quality patient care is part of the strategic approach to gain commitment from stakeholders.

6.1.4.2 External recognition and initiatives leveraged.

The theme of external recognition leveraged addresses how recognition of the organization's efforts by external bodies can have ripple effects in terms of strengthening the internal commitments to workplace integration of IENs. Formal recognition can come in various forms, including awards and invitations to share experiences with others and to participate on relevant projects at the system level:

So as a leader...you have to understand the national frame, the provincial frame and see that this is...just part of your job...I've always looked for opportunities. I've done work with...a provincially funded Ontario Hospital Association initiative...to develop a toolkit and a website to help employers know how to recruit and hire IENs...We went on a road show and did four conferences across the province and communicated to employers the key goals of integrating IENs...some tactical tools in how to do that (participant L018).

Internally, for frontline staff, managers and other stakeholders, such external involvements can create awareness, a sense of pride and re-affirm the commitment to the priority of workplace integration of IENs:

Promoting your successes... we apply for awards based on a lot of our equity work and IEP work. And we're recognized in that way... So that's a great thing for the organization to be able to say, hey, look, how good we are at this and ...if they weren't committed before, they get committed. Or others become committed because they see... there's recognition for this...it helps with fundraising... and it helps with the accreditation, to be able to say, look, here's all the things that we're doing related to...engagement or equity or diversity...it's important to be visible and vocal about this (participant L025).

System level initiatives championed by provincial organizations, such the RNAO's Best Practice Guidelines Project, has allowed the case organization to access additional resources and sustain the priority of workplace integration of IENs by implementing relevant guidelines such as *Embracing Cultural Diversity in Healthcare: Developing Cultural Competence*. Senior leaders reinforce that stated priorities by provincial or national government ministries can also have a favourable impact on the awareness and commitment to workplace integration of IENs within health care organizations:

If our government wants to provide care to diverse patient populations across all sectors...they've had the vision for some time, then we must have a diversified workforce. And so I think the government themselves has to, again, just keep being explicit about that. Get it out there and like everybody in Ontario knows about...Excellent Care for All... Everybody who's working in healthcare in Ontario should know that there is an opportunity with government support and leadership to integrate IENs into your workforce (participant L018).

To summarize, system level recognition of the organization's efforts to workplace integration of IENs can have a multiplier effect, as it also leads to further opportunities to access additional resources to re-invest towards the same priority.

6.1.4.3 Organizational responsibility to IENs and all staff.

The theme of organizational responsibility to IENs and all staff addresses the employer's role and commitment in setting employees up for success. Taking responsibility for integration means that organizations have to be committed to the staff person, and recognizing that it is not all about the individual integrating in, but also ways in which the workplace is willing to provide support appropriate for her/him:

Integration is a relevant goal for everyone that we employ in our organization. And I think when we move into the IEN category, there might be things that we would think about that would be different from what we might do for integration of an Ontario trained, St. Michael's trained health professional... (participant L018).

Supporting the IEN during her/his integration by acknowledging and building on what s/he is bringing is an example of organizational responsibility:

So integration is I think a responsibility of all organizations to be very committed to the person that you hire, that you understand...what experiences they bring, what their goals are and aspirations that they're bringing... their skills, their abilities, their culture (participant L018).

The importance of dialoguing with the individual right from the outset and supporting her/him to plan towards the achievement of her/his professional goals, is emphasized by senior leaders. Regular check-ins with the IEN would ensure that s/he is comfortable with her/his progress and accomplishments:

...once we recruit somebody, that's the beginning of the relationship...and true integration means that we give them what they need, a healthy work environment, we give them the skills and the tools, the resources and that it's kind of iterative. We like to check in with people that we've recruited to make sure we are aligning their personal professional goals with our expectations. So it's a, to me it's a partnership...part of leadership too is to help people be comfortable with who they are and where they are in their career (participant L018).

This theme reinforces the notion of integration as a two-way process by focusing on the employer role and commitment to IENs, as part of its broader commitment to all staff nurses as

well as other employee groups. Again, the notion of integration as a two-way process acknowledges the existing power imbalances that need to be addressed through deliberate organizational efforts.

6.2 Across Sub-case Analysis

This section builds on the within sub-case analysis in the previous sections. The purpose of the across sub-case analysis is to gain further insights about the organizational factors that facilitate workplace integration of IENs by comparing the perspectives of the four sub-cases or participant groups: IENs, peers and mentors, managers and directors, and senior managers. Through the process of re-examining the data for areas of convergence and divergence between the four sub-cases, the eleven themes presented as part of the within sub-case analysis are collapsed into five broad themes: (i) workforce diversity; (ii) policies promoting equity principles; (iii) leadership commitment to equity; (iv) engagement with the broader community; and (iv) avoiding common pitfalls.

All five broad themes are common to all of the sub-cases even if the sub-themes may vary. Generally, there is convergence on sub-themes related to importance of the nurse manager's support, professional growth opportunities, organizational mission, IEN-specific initiatives and a supportive external environment. Senior managers as well as managers/directors emphasize the importance of a strategic organization-wide approach, a focus on equity, diversity and inclusion, as well as of valuing of IENs' contributions. IENs add importance of policy support for dealing with abusive patients and a process of celebrating IENs. Table 8 illustrates a summary of how the sub-themes are clustered. Sub-themes are organized according to how frequently they appear, with those that are highlighted by all or most sub-cases at the top, followed by those mentioned by only two or one of the sub-cases.

Table 8 Across Sub-case Analysis: Organizational Factors of Workplace Integration of IENs – Summary of Themes/Sub-themes

Organizational factors of workplace integration of IENs	IENs	Peers/ Mentors	Mgrs/ Directors	Senior Mgrs
6.2.1 Workforce diversity				
HR active in tracking IEN recruitment & retention of diverse staff – IENs/IEPs plus diverse Canadian educated, support for staff who are underemployed IENs/IEPs	x	x	x	x
Hospital's teaching designation promotes diversity, open and accepting team culture	x	x		x
Staff of similar backgrounds –sense of community/belonging, able to be themselves/speak mother tongue	x	x	x	
6.2.2 Policies promoting equity principles				
Organizational history & mission – explicit discussion of values/ acceptance of all, priority given to marginalized population	x	x	x	x
Applying equity lens to all policies – Education on Equity vs. Equality, rebalancing policies acknowledging multilingual skills of IENs	x	x	x	x
Senior leaders as champions, strategic priority of IEN integration aligned with core priority of quality of care, proactive communication on all agendas, incl. unit managers and IENs themselves, accessing additional funding to enhance initiatives e.g. implementation of Best Practice Guidelines for Healthy Work Environments for Nurses (e.g. embracing cultural diversity, managing violence in workplace)		x	x	x
6.2.3 Leadership commitment to equity				
Clarity/comfort re. equity & implement IEN-specific initiatives – communication/language, cultural orientation, buddy/mentoring systems, platforms to connect IENs, career coaching	x	x	x	x
Professional development (in house education, internships, fellowships) available – communication to IENs/all nurses, accommodations	x	x	x	x
Encouragement from nurse managers, open/sensitive style of management, follow up on performance appraisal re. learning goals & concrete supports for future growth	x	x		x
Celebration of IENs through recognition awards, valuing of IENs, focusing on what they bring – “two-way”	x		x	x
6.2.4 Engagement with broader community				
Awards that recognize workplace for success with IENs	x		x	x
Senior leaders/workplace seen as expert resource for IEN integration	x		x	x
Community engagement to assess/respond to needs			x	x
6.2.5 Avoiding common pitfalls				
Insufficient analysis and education re. equity (vs. equality) – result: lack of IEN specific initiatives, policy contradictions re. value of IEN's multi-lingual skills and use of mother tongue, lack of support for career progression	x	x	x	x
Wavering commitment in parts of organization, competing priorities	x		x	
Intolerant behaviours of patients/families and colleagues – hurtful even though policies and supports in place	x			
<i>Note: Bolding and size of the “x” indicate relative degree of emphasis.</i>				

6.2.1 Workforce diversity.

With the theme of workforce diversity, all sub-cases agree that the level of diversity in the staff at the case organization is one of the main facilitators of workplace integration of IENs. Diversity helps create a sense of comfort and belonging for IENs. There is a common understanding that the organization's mission, and designation as a teaching hospital, provides rationale for ensuring that policies and practices are in place so that like patients, staff of all backgrounds are also welcomed and valued. Senior leaders, managers/directors and IENs have expectations that the HR department will be a key player at the corporate level in helping sustain the focus and tracking outcomes related to the hiring, progress and retention of IENs.

IENs and mentors/peers attribute the diversity of the nursing workforce to having an open and accepting team culture. Aside from how the team becomes more responsive to needs of patients from diverse backgrounds, they speak to how IENs as newly settling immigrants also struggle and need to be given a chance. They appreciate the hiring managers' consideration and interest in recruiting IENs for the team, especially their sensitivity to those IENs who are already on staff but underemployed as clinical assistants and who are actively working towards their Ontario nursing registration.

Several IENs specify how the feeling of being supported and included is accentuated when their colleagues are of a cultural and linguistic background similar to their own. Speaking to others in their mother tongue strengthens the connection and creates a sense of community. On the other hand, they also have a heightened awareness of how this in turn can sometimes make others feel excluded:

Because sometimes...so at night time, we are 13 nurses and 10 are Filipinos and three are non-Filipinos. And what we do, we group each other and talk in Tagalog while we're eating in the lunchroom. So what would you feel if you were one of those three? (participant I013)

The organization's deliberate efforts to diversify the nursing workforce are a key factor in promoting the IENs' sense of belonging and integration in the workplace. Human resource departments have a vital role in ensuring recruitment and retention practices are fair and transparent.

6.2.2 Policies promoting equity principles.

The theme of policies for equity, diversity and inclusion addresses how the hospital's efforts related to health equity is an effective frame for embedding the priority of workplace integration of IENs.

The case organization's historical roots, and sustained mission and values of caring for the homeless and other marginalized populations, are clearly seen by all sub-cases as linked to acceptance of patients and staff from all backgrounds. As stated by an IEN participant, this is viewed as foundational to an organizational context that facilitates workplace integration of IENs:

It's the values of St. Mike's...we work with the very marginalized population, very diverse and very challenging. And to do the best job, you have to have diverse workforce. And what's a better way than to have diversity in your nurses (participant 1027).

The values of caring for groups that others will not bother with are talked about explicitly with staff right from the time they are recruited and oriented to the organization. One of the senior managers states:

So if you go to emerg [emergency department] and you walk around, you see that happens time and time again by the staff who are never discouraged by the fact that patients are their own worst enemies in front of them, right... You can go to some places where they throw them out on the street, right, like we don't want you here. You know, St. Mike's attitude is, if you need care, then we want you to come here (participant L024).

Accessing additional funding from external sources assists in ensuring that the priority of IEN/IEP integration stays at the forefront. Two such examples at the case organization are: (i) becoming a Best Practice Spotlight Organization for implementation of RNAO's best practice guidelines on embracing cultural diversity and managing violence in the workplace; and (ii) becoming a site for piloting the IEP Mentoring initiative as a systemic change project of the MCI.

At the corporate level, it is challenging to determine which department will be the lead for implementing and monitoring the agendas for equity, diversity and inclusion. The case organization has had the experiences of having a clinical program as well as the human resources department be the lead and each have had their own set of challenges. Regardless, all sub-cases agree that the senior-most leaders have to be visibly championing the cause of health equity in order for others to feel reassured that the priorities such as workplace integration of IENs will be acted upon. One of the peers/mentors states: "I would say it [priority of IEN/IEP integration] would obviously come from the leadership down. Because it's not something that can just be, you know, from unit to unit. It is really something... from the CEO downwards" (participant M007).

While all sub-cases talk about the challenges of serving the marginalized patient population, it is only the IENs who describe the racist and hurtful behaviours that are directed towards them and other nurses of colour. Support from peers and managers is appreciated by IENs: "Sometimes they really use some bad words to us...but luckily we have other staff, they help us to talk to the patient...or take over from us... the manager comes and gets involved and talks to the patient..." (participant I020). There appears to be wide-spread awareness of the specific protocol on dealing with abusive behaviours and violent situations involving patients.

The organization's investment in implementation of relevant best practice guidelines and staff development further demonstrates its commitment to creating a healthy work environment for nurses. The organization's actions on the broader agenda and specific policies related to equity, diversity and inclusion, challenges historical circumstances and dominant norms. There is an acknowledgment of the differing realities faced by staff, including IENs, who may be in a position of disadvantage; these equity-focused actions facilitate workplace integration of IENs.

6.2.3 Leadership commitment to equity.

The theme of leadership commitment to equity addresses the various opportunities that managers and leaders have to apply an equity lens in their roles and to implement pertinent supports to facilitate workplace integration of IENs. According to three of the sub-cases, the nurse manager's leadership style and sensitivity towards IENs sets the tone with the rest of the team, and for their integration in the workplace: "Because we have meetings...they welcome opinions, suggestions...for the improvements of our units...they ask for our ideas" (participant I008).

The professional development opportunities for nurses are highlighted by all sub-cases as important for growth and integration of IENs in the workplace: "I think that with the opportunities to further grow and develop, you continually integrate" (participant L006). Managers/directors as well as IENs give numerous examples of in-house education, internships or fellowships, which are directly required for their roles and assignments. Senior staff members acting as buddies and mentors are seen as crucial teachers for the early transition phase. During the bi-annual performance appraisal process, managers inquire about goals and aspirations they have for future growth; concrete support or follow up for achieving these is expected by IENs. Aside from scheduling accommodations for coursework offsite, IENs may need career coaching

in order to successfully compete for promotions. Managers/directors acknowledge that other employees have also raised the need for career coaching and succession planning in staff engagement surveys. Peers/mentors reinforce how learning goals and plans have to be clear and customized for the individual. Strategies for addressing needs do not have to be limited to the specific unit where the individual is assigned, but more broadly in terms of how other parts of the hospital could play a role as well.

Senior managers describe investment in the growth of the IEN beyond the initial transition as important; encouraging IENs to in turn contribute to the development of others promotes their integration in the workplace:

It's not just okay, now they're here and they're fully working and my job is done. It's now how do they contribute back to the role of IENs. You know, it's always thinking of maximizing your investment for the best of that individual in your organization (participant L018).

Even though IEN specific initiatives undertaken in the past have not all been sustained, managers/directors and IENs describe them in a positive light as the case organization had been the first healthcare employer in Ontario to implement such projects. Managers/directors elaborated on how the participants benefited from concrete supports in the areas of communication and language, cultural orientation, networking and mentoring. Education to become culturally sensitive and competent is acknowledged by IENs and peers/mentors, especially in the context of the patient population being served: "We've got some seminars about respecting different kind of cultures...because back home, we seldom work with different people" (participant I017).

Managers/directors agree that mentoring is a useful strategy for supporting IENs and in fact is needed for all newly hired staff. Nurse Managers emphasize the need to treat all staff equally and take an individualized approach to address learning needs, to avoid IENs feeling

targeted. Senior managers agree that there is a conundrum between isolating IENs as a specific group to identify, and to respond to their unique needs, as opposed to integrating them with the rest of the team and hope that their needs will be met:

I think that's an important enabler...to not isolate and that's an important part of integration...integration should be seamless if you can get it there...and that is a bit of a dichotomy because if you can't identify and isolate in order to understand the gaps, you can't move to that full integration and yet, the isolation and targeting of any particular group can make people feel uncomfortable (participant L018).

At the senior management level, there is greater clarity and comfort that from an equity perspective, it is acceptable that different supports may be required for IENs in order for them to achieve workplace integration:

But one of the discussions I had with our nurse leaders at one point, like the new grads, we isolate them because they're new grads and they're not the same as our three and five and 20 year nurses. So it's getting people to be comfortable with being different is okay (participant L018).

The concept of equity is spontaneously raised by senior leaders and managers who have been immersed in the Inner City Health program, and a definition is offered by one participant: "Equity is more than just treating everyone equally, in fact, it means doing more for some groups, because they start from a position of inequity in the first place...to bolster their position, you have to do more" (participant L026). Greater clarity and application of the equity lens across the organization will serve as an effective facilitator of workplace integration of IENs.

Managers/directors state that shifting the focus to valuing what the IENs brings, not just what is needed so they can fit in, is necessary in order to think of workplace integration as a "multi-way" process. In addition to benefits with delivering more responsive care for patients, IENs facilitate informal learning for their peers about other cultures and concepts of health and wellbeing. The broader diversity contributes to the culture on the team and the unit. Senior managers reinforce that for integration to happen, it needs to be thought of as "two-way", by

highlighting the responsibility of the workplace organization. There is an expectation that managers would see the value of IENs as well as all new staff. Through dialogue and support, there is attention paid to IENs' goals and aspirations and how these could be facilitated through professional development: "Being able to know what the individual needs when they're coming to work in our organization...because any integration is dependent on at least two people and (the onus) has been on the one person being hired..." (participant L018).

The case organization has an awards program that promotes the mission and values and each year, celebrates individuals who have excelled in demonstrating these:

...the values and action award winners of the year...so that's an example of promoting the six values...it creates a buzz and people talk about it...we make a big deal of it...because these are people who do extraordinary things that are above and beyond anything you could normally expect or reasonably expect from a staff member but they go much further because situations seem to warrant it and they were happy to do that (participant L024).

While senior managers speak about this in a broader context of reinforcing the mission and values, IENs raise it with a view of heightening organization-wide awareness about their contributions, especially if more of them were profiled as winners of such recognition awards: "If more of the internationally educated have the opportunity to be even nominated by their colleagues, that way the organization would be more aware of IENs...IENs [are seen as] more valued too..." (participant I015). An organizational context that overtly celebrates IENs is an effective facilitator of workplace integration of IENs.

To summarize this theme, leadership commitment to equity entails all leaders and managers having a firm grasp on the concept of equity and acting in situations where their influence can facilitate workplace integration of IENs.

6.2.4 Engagement with the external community.

The theme of engaging with the external community addresses how through its leaders' involvement at the system level, the cause of workplace integration of IENs is furthered within the case organization itself. Senior leaders and managers/directors describe how the strategic priority of recruiting and integrating IENs emerged from the organization's engagement with its community stakeholders. IENs and other IEPs were part of the hospital's catchment area; their needs to integrate were also aligned with the organization's human resource needs. They explain how the external community environment reinforces the organization's efforts to facilitate workplace integration of IENs: "It met our staff shortages needs...not just ours but broader than St. Mike's ...because it was IEPs, not IENs. So like there were people who were not health related" (participant L005).

The case organization's commitment to addressing barriers by IEPs within its community is noticed by external stakeholders broadly since human resource needs are experienced at the system level as well. Prominent awards that recognize the case organization for its success with IEP/ IEN related work help reinforce the importance to internal stakeholders:

IEP mentorship program that we had here...I think first of all, the knowledge of knowing that it existed at St. Mike's, there was a sense of pride in the organization that we were doing something...even though they might not be involved (participant L005).

This recognition results in the case organization getting known as an expert resource at the broader system level; it is sought out and consulted for its experience and expertise with supporting IENs and IEPs. Senior leaders' involvement in external projects or agencies focused on IENs is also reinforcing for those at the case organization: "I am on the board of [name withheld] and ... so not only do they see that I'm saying we should do this but they're saying, wow, she must really think this is important, right?" (participant L018). The case organization's

involvement in accepting IENs for job shadowing and clinical placements, as part of bridge training programs, is a simple but meaningful way that reiterates the hospital's commitment at the frontline for nurses and facilitates workplace integration of IENs.

This theme demonstrates the potential for organizations to have a broader impact on integration of IENs by engaging with the external community. Greater responsiveness to diverse community needs, as well as IEN integration at the system level and within the profession, are necessary for such potential impacts.

6.2.5 Avoiding common pitfalls.

The case organization has undertaken notable strategies which serve as building blocks to facilitate the workplace integration of IENs. Despite all of its achievements, there are ongoing challenges that speak to how even the case organization's efforts are a work in progress that others can also learn from. The challenges include: wavering commitment in parts of the organization; sustaining the commitment; insufficient analysis and education about equity; implicit contradictions about IENs' multi-lingual skills; lack of support for career progression; and intolerant behaviours of patients/families and colleagues.

An uneven application of hiring policies across different units or clinical areas within the hospital is noticed by one IEN participant: "I'm not sure if the leadership from all the services is aware of all the supports [with recruitment and transition] that are out there" (participant I027). Another IEN participant speculates that with greater fiscal constraints, new graduates may be preferred as the years of experience that IENs bring results in higher salary costs and can serve as a barrier:

I think right now...I don't think they'd take more IEN. I think the problem, they want the new graduates from here...international educated nurse... (as an IEN) you get more pay, when you come here, you are not starting from the beginning...But now I hear they

prefer new graduate here because of the budget, because they pay less new graduates than the more experienced IEN (participant I021).

There is concern that corporate level policy commitments to integration of IENs may not always get implemented at the unit level. This, coupled with the IEN's lack of familiarity and ability to self-advocate, point to the need for some pro-active communication. A supportive and proactive communication strategy could outline all of the available opportunities, along with what is expected in terms of the typical trajectory of the IEN's development. A peer/mentor speaks to this:

If they set up a policy for IENs, at a corporate level, I think what is needed is in a small scale, on a unit level...follow-up on those policies. And those policies should be known, should be communicated to IENs, not only say that there's a policy ... what to expect and they say, okay, this is what I need to do to be able to integrate better ...you'd be encouraged to do more training...by your manager or your educator to be more involved. And so that you will know what is expected of you...For nurses that have been there for a while, they should be encouraged to participate in policymaking or be approached and be encouraged to be involved (participant P002).

An ongoing communication strategy to create awareness and understanding of workplace integration of IENs across the case organization is reiterated by one manager/director participant when acknowledging accomplishments: "We've won all kinds of awards and I think we deserve them...but by the same token, I think we still have a lot left to do for... the general staff population to become aware [of IENs/IEPs]" (participant L026).

The struggle to sustain the focus on workplace integration of IENs over the long term is real for SMH as there are multiple priorities and demands on the limited resources within the organization. Managers/directors reflect on the benefits of the IEP Mentoring Program and the efforts championed by the Human Resources department for a period of time: "so many good things that suddenly come to an end for XYZ reasons, funding maybe ..." (participant L026). Senior leaders emphasize the need for a deliberate and strategic approach whereby the

commitment to workplace integration of IENs is aligned with the organization's core priorities and all areas are held accountable for key outcomes. Being explicit and keeping the agenda of equity, diversity and inclusion on all the decision-making platforms is challenging, especially when there are competing issues requiring the organization's attention and resources:

And the other barrier I think, which is true in all busy organizations, is if we're not again explicit and clear and keep the IEN human resource strategy visible and on an annual basis, looking at how many IENs did you hire, how are they doing, what was their turnover, those sorts of things. So measuring the impact of our strategies...it's a barrier if you don't do it (participant L018).

The issues of who has the lead at the corporate level and from a structural point of view are not easy to resolve:

I've seen other organizations try to do what St. Mike's has done and create an office of diversity or... something somewhere that's all they do. And that to me is not integration. And I think we've had a measure of success here because ... of a number of clinical programs as part of the portfolio ...If you just create an office of diversity or an office of equity, it just becomes something out on its own....no link to clinical care delivery.... those people in those positions have no credibility (participant L025).

There is tension about how and if HR departments can be an effective lead for the agenda of equity, diversity and inclusion, compared to clinical portfolios:

I thought if we're going to do this, it's going to be corporate...So when we offered mentorships...it was open to everybody... we integrated that program into the human resources department... And I fought hard for that, there was a resistance to it...As much as I wanted to integrate it into HR, I think it failed. And maybe it was the wrong approach. Because it took it out of the clinical realm and put it into the HR recruitment realm...I don't know what the answer is but I think it's some combination of the two (participant L025).

While the lack of dedicated resources is a definite concern, nurse managers struggle with using the equity lens and as a result IEN specific initiatives do not seem to resonate for them. Managers state the importance of not singling out IENs and treating them equally to the rest of the nursing team as the rationale. One senior manager explains how this approach is problematic:

We have to constantly remind our staff that not everybody starts from the same position...you may perceive as a manager that you treat everyone equally or have that as a goal...that approach could be reinforcing status quo and systemic barriers (participant L025).

Specific initiatives such as the former IEP Mentoring Program and the Language and Communication Course for IENs have been offered sporadically, and those who participated, speak about the positive experience and sustained benefits from such training. IENs reflect on the valuable networking promoted by the specific mentoring project. For many, this was the only way of connecting with someone who had been on a similar journey of being internationally educated and integrating into the Canadian workplace. IENs suggest that organizational efforts to create such mechanisms to promote connections and a sense of community amongst IENs, would facilitate their integration in the workplace.

The lack of resolve between identifying IENs to be responsive versus treating them the same as the rest of the team and risking not meeting their needs, is a continuous tension. This dichotomy also emerges in the organization's awards or recognition program. An IEN participant notes a lack of awareness or engagement in the case organization's awards program and specific efforts to support more IENs to access the awards program would signal to others in the organization that staff from certain backgrounds are valuable assets:

I think if more of the internationally educated have the opportunity to be even nominated by their colleagues, that way ...the organization would be more aware that their internationally educated nurses are valued too. They have good judgment and all that. But I haven't seen many of the internationally educated, because there's a lot already of us like in St. Mike's that's not even nominated for the awards (participant I015).

Managers/directors recognize the value of a diverse staff team, including the camaraderie between IENs and other nurses who are of a similar heritage. Yet they are also clear about the policy that English is the language of the workplace to ensure inclusion of the entire team:

The expectation is that you speak English...so when you are practicing, when you're away from the unit you, people are free to, to speak their mother languages but when you're in a work environment and you're in a team, the expectation is that you're speaking English because that is the common language that everybody speaks (participant L009).

IENs are also aware of how their camaraderie and use of mother tongue amongst nurses of similar backgrounds might feel exclusive to other colleagues:

I know the feeling when someone is talking different language and you don't understand it...like when I'm listening to Chinese too...so we're trying to avoid it but sometimes it's just so typical...but what I do is I look around, okay, is there any Canadian who only speaks English here, then I proceed to our conversation in my own, in our own language. Which is really nice sometimes, you miss that (participant I013).

However, when it comes to caring for patients and families who are from backgrounds similar to their own, IENs are encouraged to use their non-English skills. They are seen as a valuable resource for reducing language or cultural barriers which could impact clinical assessment or treatment during the patient's hospitalization, as well as increase costs in terms of time and interpretation services. Managers/directors acknowledge how this might be perceived as a contradiction and create a tension for IENs. As a result, there is a need to revisit and restate the related policies of *Dress & Deportment* and *Language Translation/Cultural Interpretation* at the case organization.

Peers/mentors note how some IENs, despite extensive qualifications, are not overly eager to get involved on committees, or to apply for leadership roles, and probably need encouragement at the individual level to know that others have confidence in them. There is concern that managers' workloads and lack of sensitivity may prevent them from providing IENs with individualized attention. Peers/mentors recognize that scheduling time off to pursue professional development is challenging for many nurses, not just IENs:

The only problem with the organization is that with internationally trained nurses or even nurses who are trained here...when we want to improve our education...our skills and we want some time off; I think it's difficult to take some time off (participant P002).

While attending in-services or courses pertaining to the immediate role do not seem to have been an issue, the lack of direction and feedback following application for leadership roles have been discouraging for some IEN participants:

I strongly believe in continuing education...I have a Masters, I have other qualifications...and I'm still at the bedside...but it's not because I want to be...I've applied for several positions and there's always, you know, oh, the interview went well, you did well, but we found somebody who's better, you know...I have not received any helpful feedback (participant I012).

Post-application debriefing and career coaching is recommended by some IEN participants:

“Having an opportunity to grow and become more of a leader, how do you do that? So if you know...what the steps you need to take, to get there, that'd be helpful” (participant I027).

Work schedules or related accommodations to pursue aspirations of higher education have prevented other IENs from integrating more fully at the case organization:

I know other senior nurses too who wanted to maybe become like ...having aspiration like to do other than bedside...I wanted actually to be a clinical instructor at one time...management wasn't supportive of doing this schedule for us. Like it was such a hindrance, it's such a big job for me...I have to ask...then she okayed it but during the scheduling they don't give me days that I wanted to be off. Because I have to be in school...I have to find someone all the time like to work for me...I find that so distracting...I gave up the course... I took that, just one course and I didn't pursue it again (participant I015).

IENs highlight particular challenges in handling patients and/or their families who target them with overt discriminatory or racist behaviours:

They look at your skin, they say, oh, I don't want to be treated by a brown skin or a black skin. I want to be treated by Canadian, a white skin. And then I said, my co-worker who is a Chinese, her colour is lighter than me, she talked to her...It's really, sometimes you feel disrespected (participant I013).

Although many of the problematic behaviours are rationalized by the IENs as a result of difficult circumstances faced by patients themselves, such as homelessness or suffering from mental health issues or addictions, these incidents cause much distress as they come across as personal

attacks. IEN participants acknowledge that such situations have less to do with having obtained their nursing education outside of Canada and more to do with their racial background: "...it's not something to do with the internationally educated...it's something to do with the colour" (participant I013).

Negative attitudes and behaviours of other more senior nurses are also highlighted by IENs, especially during the earlier transition period:

There's more negativity than positivity...it's not only related to international (nurses) but the same thing goes with all new staff that comes to the workplace. And that is the biggest problem of the nursing...I've been eaten alive in two hospitals (participant I023).

IENs acknowledge that such problematic behaviour of senior nurses is not just directed at IENs or nurses of color, but probably towards all new nurses.

To summarize, the theme of avoiding common pitfalls has, at its core, the potential for organizations and leaders to lose sight of equity principles. Since many managers and leaders may have an inadequate analysis of the concept of equity, the possibility of unfair and inequitable policies and practices is quite real. Continuous education and efforts to "unpack" and dialogue about equity principles in relation to workforce issues are warranted.

6.3 Summary

The findings related to the organizational facilitators of IEN integration focus on the workplace environment's influence on IENs. One of the goals of this research is to understand the organizational context as it pertains to workplace integration of IENs as a specific segment of the workforce. The choice of the case study approach is not to view SMH as an intrinsic case, but rather to see it as an instrumental case to inform our thinking about how organizations can promote integration of IENs in their workplaces. Using SMH as the point of reference, the study

identifies factors perceived by participants as having facilitated workplace integration of IENs, as well as challenges that still have to be addressed by the case organization, and avoided as common pitfalls by others.

While the major themes related to the organizational context link with corresponding dimensions of the conceptual framework, refinement of the framework is necessary to accentuate some of the key findings from this research. Some emerging factors are broad in scope and have relevance for IENs, as well as IEPs and other groups of staff who may experience inequities or exclusion. Questions about IENs or the workforce also prompted references to the diversity and vulnerability of the patient population served by the case organization. The themes identified clearly link with the notions of a systematic organization-wide approach and leadership commitment to sustaining the priority of workplace integration of IENs. Further questions emerge about whether the organizational context affects IENs differently than their Canadian-educated counterparts. These will be additional areas of exploration and discussion in chapter 7.

Chapter 7 - Discussion and Implications

This final chapter builds on the within sub-case and across sub-case analyses, related to the two broad but linked areas of inquiry found in chapters 5 and 6. A revised definition and conceptual framework for workplace integration of IENs are first presented and discussed. An integrated discussion of the links between the guiding and final concepts follows. Existing works are used to situate the findings and further support and illuminate the unique contribution of my research. In an effort to understand what is meant when an IEN is described as having “integrated” in the workplace, and how this is influenced by the organizational context, two broad questions that warrant further discussion emerge: (i) how do expectations surrounding workplace integration of IENs relate to integration of Canadian educated nurses? (ii) how does the organizational context influence the workplace integration of IENs differently than the integration of Canadian educated nurses? Next, the strengths and limitations of this research are summarized, followed by an outline of future implications for nursing employers, IENs, policy makers, regulators, funders and educators and researchers. Finally, the chapter concludes with key take home messages from the study.

7.1 Workplace Integration of IENs

This research on workplace integration of IENs was guided by concepts borrowed from the discourse found in immigrant and refugee studies, observations about gaps in nursing employers’ approaches to organization-wide efforts to facilitate workplace integration of IENs, and my own professional experiences. The findings from this research are summarized in Figure 10. The three major themes that describe an “integrated” IEN in the workplace are: (i) being a “Canadian nurse with international experience”; (ii) progressing on the leadership journey; and

(iii) perseverance in overcoming challenges. Five major themes on how the organizational context influences workplace integration of IENs include: (i) workforce diversity; (ii) policies promoting equity principles; (iii) leadership commitment to equity; (iv) engagement with the broader community; and (v) avoiding common pitfalls.

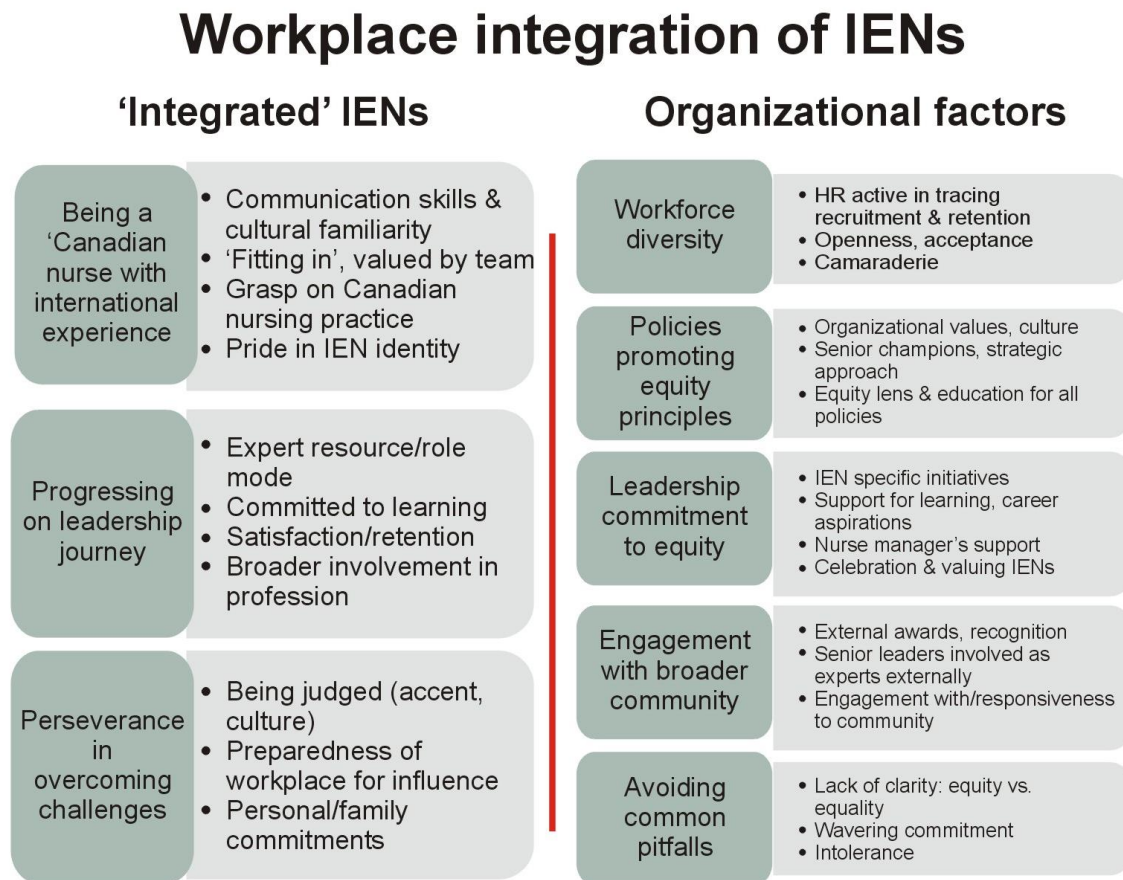


Figure 10 Summary of Research Findings

Overall, these themes are aligned with the definition and conceptual framework for workplace integration of IENs that guided the research. The research findings, and specifically

these major themes, inform the refinement of the definition and framework to make them more relevant for workplace integration of IENs in the Canadian healthcare context.

7.1.1 Definition of workplace integration of IENs revisited.

The revised definition resulting from this research is stated in Figure 11. It provides nursing with a vision of what IENs' workplace integration can be, both at the organization and the IENs' levels. The notion of two-way integration in the guiding concepts remains in the revised definition. Two-way integration in the workplace amplifies the idea that the process involves efforts on the part of the IEN as well as the employer. Similarly, changes resulting from workplace integration occur both at the individual IEN and the organizational levels.

Workplace integration of IENs...

...is a two-way process, resulting in changes at both the individual IEN and the employer organization levels. IENs are valued as 'Canadian nurses with international experience' who are progressing on their leadership journey by influencing patient care and nursing practice. The organization-wide leadership commitment to equity translates into accountability for sustaining a diverse workforce, policies which promote equity principles and responsive engagement with broader community.

Figure 11 Revised Definition of Workplace Integration of IENs

The organizational environment is inclusive in all respects and this way, barriers to fairness, equity, acceptance, belonging and participation are eliminated. That is, IENs who are immersed in such a workplace do not just "fit in" in order to survive, but instead they thrive to develop and perform at their optimal levels. IENs have equitable opportunities for career advancement and

mobility; they experience fair and equitable treatment by colleagues, managers, patients and families. IENs are encouraged to share their expertise from their former international practice environments, so that lessons can be drawn for the workplace to lead to better outcomes for the nursing care of patients. The workplace achieves and sustains this context through a systematic process driven by senior leaders embroiling all levels and parts of the organization. Furthermore, the final definition stresses accountability and provides parameters for outcomes that could be monitored and tracked.

7.1.2 Refined conceptual framework.

The refined conceptual framework in Figure 12 builds on the definition. It provides a pictorial representation of workplace integration of IENs and reflects the emphases that emerged in this research. When IENs work in an organization that is committed to equity, diversity and inclusion, their integration is facilitated.

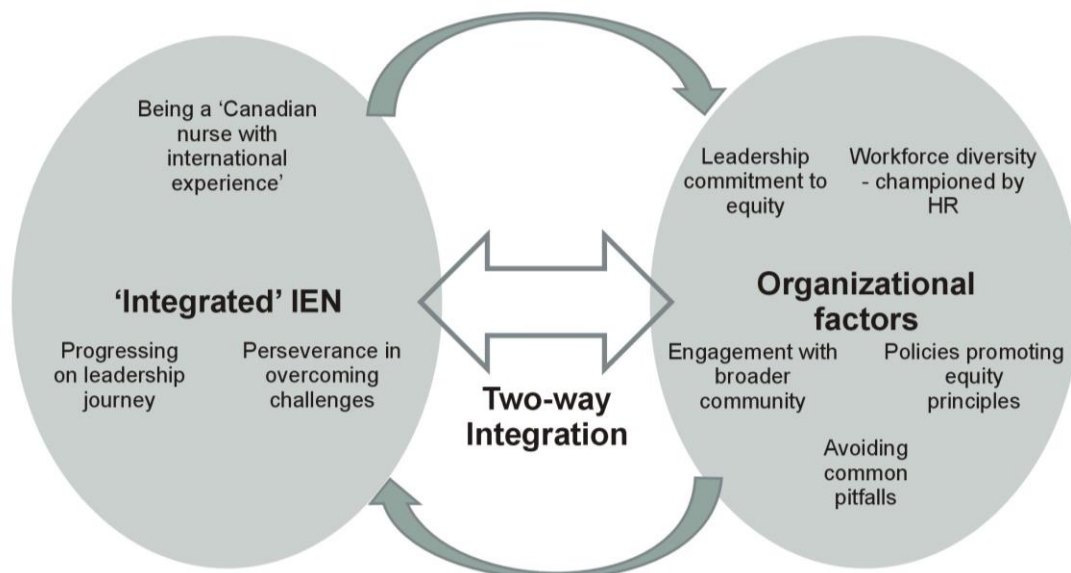


Figure 12 Workplace Integration of IENs – Refined Framework

The organizational leadership's application of the equity lens to all decisions about resources and policies translates into practices that strive for equitable outcomes for IENs. Diversity in the organization's workforce is a major facilitator and it is achieved by HR departments championing appropriate recruitment and retention strategies. The relevance of and responsiveness to the external community are also reflected through the organization's active engagement. The framework highlights that organizations have to continue to be diligent as there will be various pitfalls along the way that need to be dealt with. The refined framework clarifies that IENs have moved beyond transition and are being "Canadian nurses with international experiences", who are progressing on their leadership journey while still persevering in overcoming challenges.

7.2 Integrated Discussion: Linking Findings to Guiding Concepts and Existing Works

The key dimensions of the final conceptual framework and definition refer to workplace integration of IENs as a two-way process, requiring deliberate organization-wide sustained efforts towards achieving and being accountable for results, at the levels of both the IEN and the employer organization. These conceptual dimensions are used as guideposts in further analysis of findings from this research.

7.2.1 Alignment between "integrated" IENs and domains of nursing work life.

The first area of inquiry in this research is to understand how IENs and the other sub-cases conceptualize workplace integration of IENs. Specifically, what do the sub-cases or participant groups envision when they think of an IEN who has "integrated"? The analysis was guided by the IENs' achievements aspect of the conceptual framework, which describes the four domains of nursing work life: social, cultural, economic and political. Adapted from the CCR's

(1998) work on societal integration of refugees, the domains highlight some of the key achievements that may be expected of IENs in their integration phase as opposed to the earlier stages of adapting and transitioning. These domain areas are also where social closure (Roscigno et al., 2007) may be operating and unless organizations are self-critical and determined in their efforts to address exclusionary practices, IENs may lag behind.

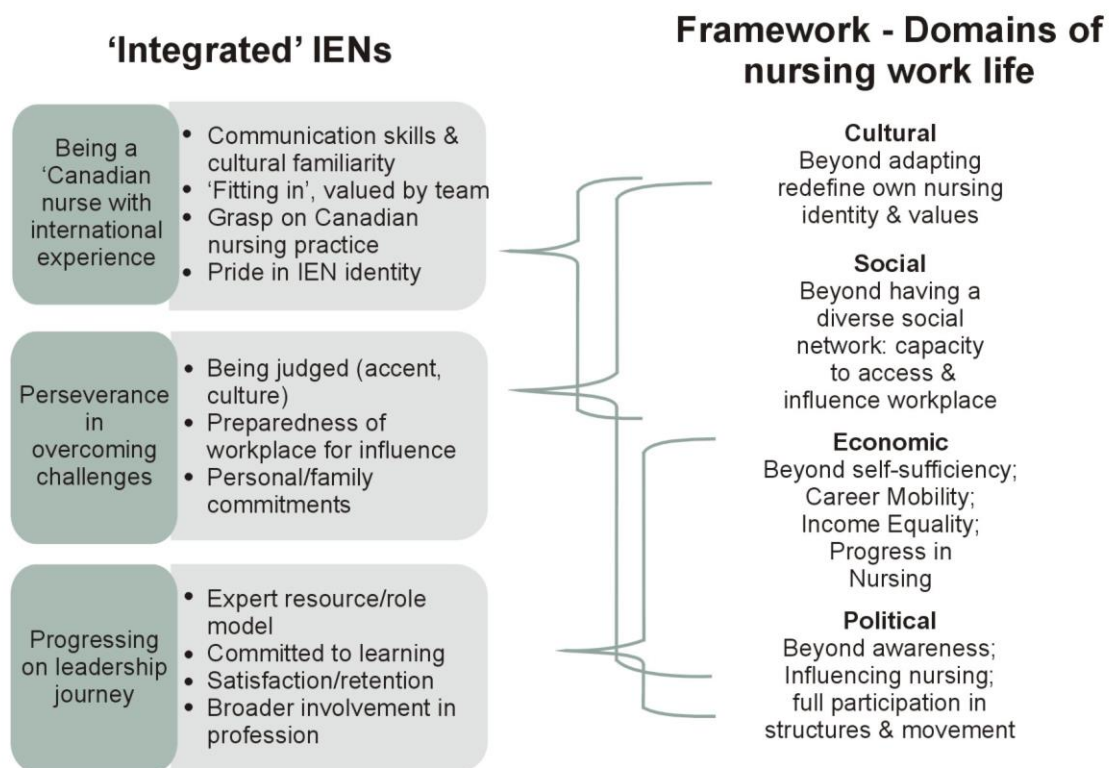


Figure 13 Linking Findings to Conceptual Framework – “Integrated IENs”

The three broad themes (and their sub-themes) emerging from this research resonate with the four domains of nursing work life in the guiding framework as depicted in Figure 13 and are discussed further next.

7.2.1.1 *Being Canadian.*

The social and cultural domains in the framework relate to the theme of being a “Canadian nurse with international experience” and its four sub-themes of: (i) communication skills and cultural familiarity; (ii) “fitting in” and being valued by the team; (iii) having a grasp on requirements of Canadian nursing practice; and (iv) pride in the IEN identity. There is an emphasis on the IENs’ overall confidence in practicing nursing in the new context derived through proficiency in English and cultural familiarity of the workplace, together with its diverse patients and staff. The clarity of social and professional expectations enables IENs to engage with the rest of the team more readily, resulting in what was commonly expressed by participants as “feeling like everyone else” or “fitting in”. Typically, these are priorities and challenges in the IENs’ transition phase and found to be recurring themes in other studies. In a recent study, the IENs’ confidence, complemented by trust, acceptance and respect from colleagues are key factors that support integration and retention of IENs (St. Pierre et al., 2015). In a broader study on IEHPs, Neiterman and Bourgeault (2015) describe the process of professional resocialization for IEHPs. They note that while some aspects of their initial socialization is retained, IEHPs have to unlearn some skills and adopt other new ones, all as part of learning “the Canadian way” (p.79).

IENTs are aware of the cultural changes in their own beliefs and attitudes that contribute to the process of “fitting in” when integrated in the workplace. Aside from adopting different models of nursing care, the IENs in this research describe collegial interactions within the team and less formal ways of relating to managers or senior leaders as examples of cultural changes when integrated in the workplace. Other researchers provide insights on IENs’ adjustment to a collaborative team approach. In a UK study by Gerrish and Griffith (2003), mentors/managers

felt that because of their prior exposures to more hierarchical cultures, IENs have difficulties adjusting to a team approach and to an environment where challenging or questioning peers or senior nurses is acceptable. Liou et al. (2013) provide a somewhat different perspective from their study of Asian nurses working in the US. Asian nurses in this study were found to have high levels of a collectivist orientation where they view themselves as part of a group, and the goals of the group supersede any personal goals thereby resulting in greater commitment to the team (Liou et al., 2013).

Having comfort and pride in the IEN identity is another sub-theme of being “Canadian nurses with international experience” when IEN are integrated. This finding of pride in one’s professional identity is also supported by Neiterman and Bourgeault (2015) study of IEHPs. IENs and senior managers participating in this research shared the perspective that you could be an IEN and also be integrated. This relates to the framework’s social domain where diversity in the IENs’ networks does not compromise the need for support and comfort derived from colleagues who are of a similar language and cultural background. On the contrary, within the context of an organization which is diverse, inclusive and that promotes equity, IENs are encouraged to be themselves and feel free to associate with whomever they wish, and not be judged. Thought leaders in the area of pluralism support the notion of how identity itself can be pluralist, and that honouring one’s own original identity need not mean rejecting other, new ones (Eck, 2015; H.H. The Aga Khan, 2010). While this supports the notion that you can in fact enjoy both identities – that is, being an IEN as well as being a Canadian nurse who has international experience, the IEN participants in this research were candid that their pride in the IEN identity only clearly surfaced once they were integrated in the workplace. In other words,

they were not usually forthright about their IEN identity and international experiences in the earlier transition phase due to fear of being judged as “less than Canadian”.

7.2.1.2 Thriving, not just surviving.

The second theme of what “integrated” IENs are has to do with progressing on the leadership journey, and has four sub-themes: (i) being viewed as expert resources/role models; (ii) commitment to learning; (iii) satisfaction as an employee and retention with the organization; and (iv) broader involvement in the profession. This theme and its sub-themes relate to the political and economic domains of the framework, as integrated IENs expect to function as professionals alongside with their peers, leading teams, participating in projects to influence practice improvements, as well as advancing in their careers. Integrated IENs are described to readily contribute to other colleagues’ development. Aside from clinical expertise, colleagues benefit from IENs’ knowledge of the role of specific cultures, traditions and religions in illness and in healing. The non-IEN participants in this research acknowledge how integrated IENs are effective as role models, mentors, preceptors and team leaders. This finding does not resonate with what generally appears in the literature about IENs and their leadership capacities. Further to Gerrish and Griffith’s (2003) explanation of IENs’ difficulties in challenging team members, mentors/managers in Ferguson et al.’s (2014) research also feel that IENs are not ready to be in charge and assume leadership of a team. Both of these studies indicate they are exploring “integration” experiences of IENs, but neither one provides any definitions, and they both seem to focus on the challenges IENs encounter while they are still adapting and transitioning into the new host environment. It is also recognized that in this research, SMH, the case organization, is an exceptional case and that while social closure may be operating to some degree, the discussion of exclusionary practices affecting IENs are limited.

In this research, involvement on unit level or hospital-wide committees and projects are viewed as leadership development and career advancing activities that integrated IENs engage in. This is contrary to Wheeler and Foster's (2013) finding that both IENs and their US educated counterparts shared similar perspectives, in that they do not value participation in committees to influence governance or decision-making, and prefer to be at the bedside. While the logistical barriers of time and cost (schedules, days off, etc.) explained in Wheeler and Foster's (2013) work are also concerns of participants in this research, the sense of apathy is not conveyed. As noted earlier, the case organization is an exceptional case and its culture of valuing nurses' involvement through continuous communication and encouragement from management could be the difference. In fact, the IEN and senior manager participants go even further and refer to involvements of integrated IENs at a broader level, providing leadership and exerting their influence outside the workplace, within the profession. Such references are not evident in the IEN related literature.

IENs and other participants in this research are not explicit about the economic gain of being integrated in the workplace - but it is noteworthy that advanced roles and involvements generally come with incentives, and so economic gains are implicit in the theme of progressing on the leadership journey. The case organization's staffing model requires all nurses to be registered at least in the RN category, and salary scales, including premiums for different shifts and added responsibilities, are all negotiated through the collective bargaining process by the union. Variations in the level of education and years of nursing experience are reflected in what pay grade the nurse is placed on when s/he first starts working. In other words, when controlled for years of experience, the salary scale for RNs who were "grandparented" by the regulator, and only had an associate degree or diploma, may be lower than the pay range for those having

upgraded to the baccalaureate or master's degree level. These structural dimensions to nurses' compensation serve as protective measures, resulting in the potential for IENs working at the case organization to have income equality with their Canadian educated peers. This finding is similar to that of Walani (2013) who concludes that while there may be other forms of discrimination, there is no wage inequality between IENs and their US educated counterparts. Boateng's (2015) study also reveals that although the long route or extended time frame before entering nursing practice is costly for IENs, once they are integrated into the profession, their incomes are comparable to their Canadian educated peers.

Commitment to learning as a sub-theme of progressing on the leadership journey is seen as a critical pre-requisite for integrated IENs to continue to develop and grow professionally. Several participants in this research place emphasis on the high levels of satisfaction and stability amongst IENs and attribute this, at least partly, to the educational opportunities and supports made available at the case organization. A study by Liou et al.'s (2013) of Asian nurses working in the US found that the willingness to stay longer in their current place of employment is explained by the higher levels of collectivistic orientation and organizational commitment. However, Winklemann-Gleed (2006) states that professional identity can be an integral part of personal identity or sense of self-worth among immigrant nurses. Career development is therefore important and if it is not encouraged by employers, immigrant nurses would be prepared to change their place of work (Winklemann-Gleed, 2006). Adeniran et al.'s (2013) research indicates that the mean number of continuing education hours and professional certifications in practice areas between IENs and US educated nurses are comparable. They also find that even though IENs enter the profession with higher education, they are less likely to go on to pursue advanced degrees and receive promotions less frequently compared with their US

educated peers. The consequence of fewer IENs in leadership roles is noted by Adeniran et al. (2013), and also supported by Premji and Etowa (2014), who document the concern about lower representation of visible minority nurses in leadership roles in Canada.

7.2.1.3 Struggles do not just vanish.

The third theme of perseverance in overcoming challenges highlights some of the difficulties that cut across all four domains of the framework. IENs may experience these challenges because social closure may be operating in explicit or implicit ways (Roscigno et al, 2007). Although IENs might make significant strides in achieving the goals of integration, they need to continue to persevere with some persistent challenges. The barriers highlighted by IENs and other participants in this research are organized according to three sub-themes: (i) being judged because of their English proficiency (including accent); (ii) lack of preparedness of the workplace to be influenced by IENs; and (iii) personal and/or family commitments.

Language, communication and cultural challenges exist to different degrees but become especially problematic when patients or colleagues get impatient and judgemental. While there is a preoccupation about IENs' proficiency in English, this can also be an example of social closure where the difference in how English is spoken or specific accents may be the reason for exclusionary behaviours (Minors et al., 1995; Weber, 1947). Some have argued that there is also a need to offer training for first language English speakers to listen to different accents (CARE Centre for IENs, 2011). Offering training in major languages of the non-English speaking patient groups is also another strategy used by some employers to become more inclusive of the diversities within their organization (CARE Centre for IENs, 2011).

Even though IENs are practicing competently and may be demonstrating leadership in various ways, they may be overlooked for development opportunities. Social closure may be

implicit in how managers and other team members are described to not always be sensitive to the cultural differences in leadership styles and self-promotional behaviours (or lack of) exhibited by IENs. As settling immigrants, IENs frequently have different demands and realities at their personal and family level. The need for re-establishing family and financial stability may have a local as well as overseas dimension, and could exert added strain on the IENs in terms of having any disposable time or income. All of these areas requiring perseverance, where social closure may be operating, are also supported by Salma et al.'s (2012) study on IENs' experiences and perceptions of career advancement and educational opportunities. Among the major themes, Salma et al. (2012) found that priority of motherhood, communication and cultural barriers and perceptions of lack of opportunity were key factors that hindered IENs' career advancement. The IENs' perseverance to transcend challenges has an underlying tone which relates to Lukes's (2005) overt face of power theory whereby organizational approaches or norms may appear to be "open" to most, but do not fully account for differences amongst the groups. As a result, the IENs' non-participation or participating in ways that are not familiar to the dominant group could be misinterpreted as incompetence leading to further exacerbation of the pressures on IENs.

7.2.1.4 Integration is "anchored" in transition.

Participants in this research make several references about the priorities and challenges of the earlier phases in order to explain what they mean by workplace integration of IENs. Like in Bradley and Ramji's (2012) study, IENs participants in this research have vivid memories of their journey to meeting the registration requirements in order to be allowed to enter the nursing profession in Canada. Once employed, the IENs, along with the other participants seem to have clear recollections of the various challenges when transitioning into the workplace. Even though

IENs are deemed “competent” by the regulatory body to enter the practice environment, there is much more formal and informal learning that has to take place during transition.

It seems that the priority during the transition phase is for IENs to continue to *become* Canadian nurses and it is only when this has been accomplished, that IENs are said to be “integrated” in the workplace. When IENs have “integrated”, they are now *being* “Canadian nurses with international experience”. In other words, the transition phase and its areas of learning or adjustment for the IENs serve as an “anchor” from which the phase of integration is envisioned, by IENs themselves as well as others who work with them. Figure 14 depicts the two distinct phases.

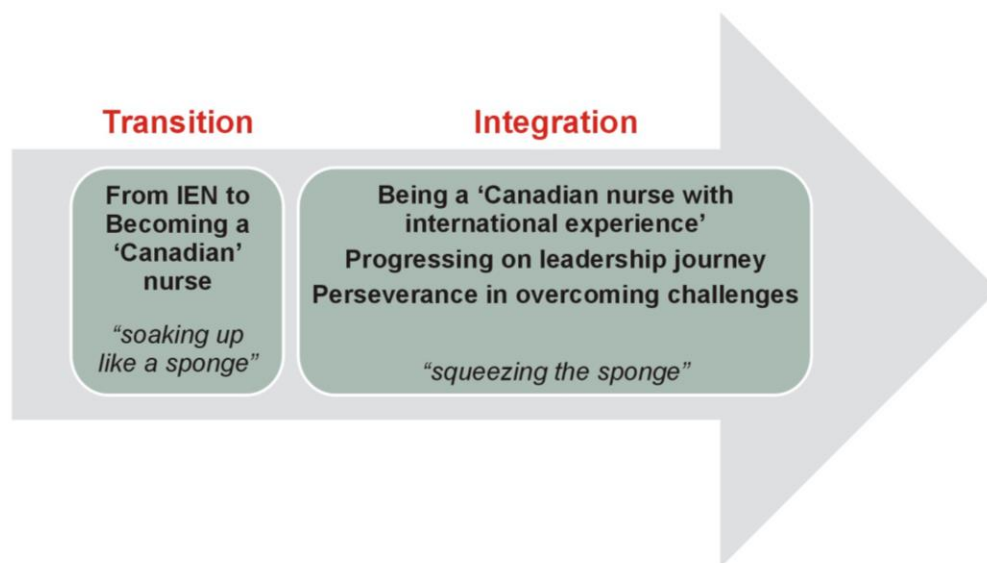


Figure 14 Transition to Integration

The analogy of a “sponge”, used by one of the participants, can be effective in differentiating the two phases. When transitioning, IENs are absorbing a lot of new information and new understandings – they are “soaking up like a sponge” to *become* Canadian nurses.

During integration, IENs “squeeze the sponge”, readily sharing their expertise and providing leadership albeit still persevering to overcome challenges – they are *being* “Canadian nurses with international experience”. A power analysis of this analogy could be interpreted in ways that devalue IENs. It may discount the international experience that IENs bring because they are like a “dry” sponge and that only the knowledge and understanding acquired in their new environment is worthy of “soaking up”. The “soaking up” phase, followed by the “squeezing the sponge” phase, could also imply that the latent dimension of power has resulted in IENs embracing the new, dominant ways as the desired state.

It is reasonable to conclude that the three themes describing the expectations of “integrated” IENs in the workplace are well aligned with the four domains of nurses’ work life aspect of the guiding framework. It is in these social, cultural, economic and political aspects of their work life, where implicit or explicit social closure prevents “integration” of IENs. Focused efforts to address exclusionary practices and cultivate a supportive organizational environment are at play when workplaces are committed to facilitating integration of IENs.

In summary, the relationship of the integration phase to the preceding transition or adaptation process is noteworthy and will re-emerge in a later discussion on how the organizational context influences the integration of IENs differently than their Canadian educated colleagues. Relating the research findings about the organizational facilitators of IEN integration to the guiding concept of the organization-wide systematic approach is discussed next.

7.2.2 Relating organizational facilitators of integration to a systematic approach.

The second area of inquiry in this research was to identify the organizational factors that influence the workplace integration of IENs. All of the sub-cases were asked to describe what it

was about the case organization that they felt facilitated or influenced workplace integration of IENs. Specifically, participants were asked to identify policies, programs or practices that contribute towards the goal of integrating IENs in the workplace. The analysis was guided by the systematic organization-wide dimension of the conceptual framework (Figure 1). The five key factors of organizational culture, leadership, communication, strategic management and resources, were adapted from the NHS Employers and University of Bradford's (2005) Positive Action framework. Each of these key factors or best practices cut across the organization and include specific considerations for workplaces committed to integration of IENs (Table 2).

Overall, the systematic organization-wide dimension of the conceptual framework is aligned with the five themes emerging in this research: (i) workforce diversity; (ii) policies promoting equity principles; (iii) leadership commitment to equity; (iv) engagement with the broader community; and (v) avoiding common pitfalls. The links between the themes and the organizational dimensions of the conceptual framework are depicted in Figure 15. However, some are not as explicit as they ought to be. Further insights based on existing works are incorporated in the discussion which follows.

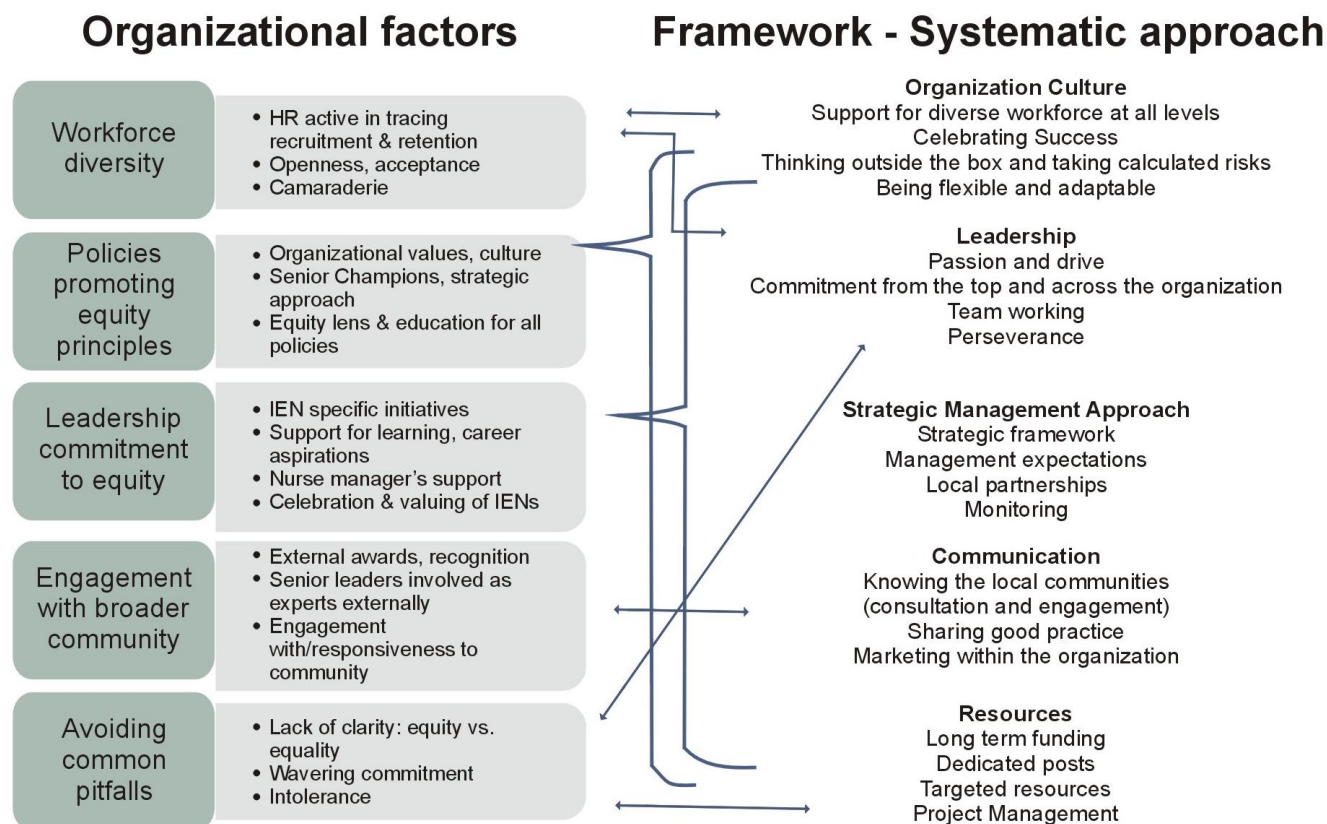


Figure 15 Linking Findings to Conceptual Framework – Organizational Facilitators

7.2.2.1 Human Resources (HR) keeps the gates open.

Workforce diversity at the case organization has been noted favourably as a key factor in creating openness, acceptance, camaraderie and a sense of belonging for IENs. Although it is implicit in the notion of an inclusive culture, the emphasis placed by research participants warrants that the vital role of HR in recruiting and integrating diverse staff be made more explicit in the conceptual framework. Various experts also agree that human resource policies and practices can be exclusionary in subtle and covert ways, as employment systems are set up for homogenous or the dominant group, and “others” can be perceived to not “fit in” (Manning, 2012; Minors et al., 1995; Weiner, 2012). This is referred to as unintended systemic or

institutional racism (Manning, 2012), and if the goal of recruiting and sustaining a diverse workforce at all levels of the organization is to be achieved, deliberate efforts are necessary (Minors, et al. 1995). The review of organizational documents and interviews with participants both indicate that recruitment of IENs/IEPs has been a strategic priority for the case organization. However, accountability systems to track and monitor the degree of workforce diversity at the case organization do not exist – in other words, information about diversity in different programs, disciplines and organizational levels is only anecdotal. This is problematic because as McKenzie (2015) puts it in terms of basic democratic principles: “if you do not count people, they do not count” (p. 4). The case organization is now part of a regional initiative to measure the level of diversity in its patient population in comparison to its community profile, by incorporating demographic questions in intake/admission processes. Similar initiatives focused on measuring workforce diversity would allow the organization to track progress on its recruitment and retention goals, including the extent to which the staff profile is reflective of its patient population.

7.2.2.2 Diversity alone is not enough.

The theme of having policies that promote equity principles links well with the systematic organization-wide nature of the guiding framework. The achievement of inclusive practices which are fair, equitable and valuing of everyone outlined in the framework, are aligned with the sub-themes from this research of: organizational values and culture, senior leaders as champions of a strategic management approach, and applying equity lens to all policies. Findings from this research as well as the conceptual framework both imply that there is a need to actively promote inclusion, and that just focusing on limiting exclusion is not enough. It is emphasized that in addition to diversity, systematic strategies to engage employees in

meaningful dialogue are required in order to create inclusive organizations (Bormann & Woods, 1999; Manning, 2012). Similarly, in the discussions related to pluralism, Eck (2015) states that “mere diversity without real encounter and relationship” could result in tensions – that is, where people from diverse backgrounds simply tolerate each other and do not get to know anything about each other or each other’s views (para. 2). She goes on to explain that pluralist approaches necessitate the “active seeking of understanding across lines of difference” (para. 3). Using the related concepts of cultural competence, Srivastava (n.d.) explains that what is required is “a willingness to accept that there are many different ways of viewing and approaching the world” (p. 8).

The theme of policies promoting equity principles reiterates how the case organization’s vision, mission and values have been critical in driving various structural and educational initiatives, in order to create an inclusive environment and facilitate workplace integration of IENs. Two specific policies requiring attention have also emerged. First, the need to ensure that policies related to the acceptable use of mother tongue is balanced with the benefit of the IENs’ diverse cultural and linguistic backgrounds to delivery of quality care. Secondly, the values of caring and respect of marginalized patients and families have to be balanced with appropriate policies and protocols for dealing with abusive behaviours that target IENs and more broadly, racialized nurses.

7.2.2.3 Leaders have to “get” equity.

The theme of leadership commitment to equity as one of the organizational factors of workplace integration of IENs links well to all of the dimensions of the conceptual framework. Leaders at the top influence managers and staff at other levels and set the tone for the culture in the workplace. This finding is supported by Drach-Zahavy’s study where nurses were found to

take the cue from nurse leaders' behaviours and were attentive to what their senior managers valued (as cited in Tilley, 2007).

The case organization's strategy to have senior leaders present at the corporate orientation of new staff, and to have explicit discussions of its values, has a lasting effect, as even participants who have been employed for several years still recall this. Schein (1984) states that the involvement of senior managers at corporate orientation sessions is an effective way to ensure that organizational values and beliefs are perpetuated by staff right from the outset. The leaders' strategic management approach to keep integration of IENs on all agendas helps translate this priority into policies and practices that are valuing of IENs and that are sensitive to their needs. However, this study highlights that the concept of equity is challenging to grasp and needs to be "unpacked" regularly. Continuous education and dialogue to further clarify the concept of equity, as opposed to equality, and how the organization can implement equitable practices, is needed for staff and managers. Learning exchanges which recognize that "the other" is both "present" and "different" and that this difference can be an opportunity and not a burden, can add to the organization's efforts towards equity (H. H. The Aga Khan, 2010).

In the review of organizational documents and discussions with participants, it seems that there is greater clarity about health equity in the context of patient care, and several programs relevant to the priority populations are in place. When it comes to offering specific supports to IENs, it appears that some nurse managers are hesitant and provide the rationale of wanting to treat all of their staff nurses "equally". For staff who might be in positions of inequity, Minors et al. (1995) explain that to achieve equitable outcomes, it is important that workplaces are also considerate of their need for differential supports. The IEN related literature has several studies

that point to specific strategies which are helpful in supporting IENs' transition into the workplace (Baumann et al., 2012; Khalili, et al., 2015; Zizzo & Xu, 2009).

Given that the frontline managers' support and openness are seen to be critical by IEN participants in this research as well as in other studies (Gerrish & Griffith, 2003; Hoxby et al., 2010; Parkouda, 2014), a focused development program for nurse managers may be appropriate. Under the broad topic of equitable practices for managing the workforce, nurse managers would benefit from different perspectives on harnessing the talents of a diverse team. Aside from key functions of employee engagement, performance appraisals and access to organizational networks (Manning, 2012), understanding cultural dimensions in leadership styles (House, et al., 2002; Konu & Viitanen, 2008) may also be relevant for nurse managers at the case organization. Some organizations have gone further and instituted accountability measures by expecting nurse managers to have the core competency of supporting IENs effectively (Romaniuk, 2015). To summarize this section, while the concept of equity exists in the guiding framework, a more explicit reference is warranted in the refined framework.

7.2.2.4 Workplace integration is connected to community integration.

The theme of engagement with the broader community is implied in the framework through references to the organizational vision and commitment, and the communication that the leadership is expected to have with external stakeholders. In a US study on the relationship between IEN hiring practices and broader community and hospital characteristics, Cho et al. (2011) found that employers in urban areas with older, more diverse and more educated populations, are more likely to report hiring IENs. These researchers explain that the findings may reflect the hospital administrators' perceptions of community receptiveness to IENs. Various experts on integration of immigrants and diverse peoples point out that employees are

part of the larger community and employers should work with and contribute to the external context (Galabuzi, 2012). In order for workplace integration to be successful, the “community as a whole must grow socially, culturally and economically as it faces up to the challenges of greater diversity” (Creticos et al., 2006, p. 3). Changes within institutions are also more likely to have a “lasting meaning only when there is a social mindset to sustain them” (H. H. The Aga Khan, 2010, para. 82). In summary, engagement with the external community is not portrayed clearly in the current rendition of the framework and ought to be amplified in the revised version.

7.2.2.5 Workplaces also have to persevere.

The theme of avoiding common pitfalls relates to all aspects of the organizational dimension of the guiding framework. It highlights persistent challenges in sustaining the commitment and getting broad based buy-in for workplace integration of IENs. Several participants refer to how other priorities in the organization can compete for finite resources, resulting in a shift away from the focus on workplace integration of IENs. Competing demands, coupled with a lack of clarity about equity, can have the inadvertent effect of IENs being “left off the agenda” as in Lukes’s (2005) second or covert dimension of power.

While the painful effects of intolerance and racism are emphasized, IEN participants acknowledge that the case organization has devoted significant resources, by implementing the RNAO best practice guidelines on managing workplace violence. The experiences of everyday violence are not limited to IENs, but in fact reported in several studies in nursing (Boateng, 2015; Das Gupta, 2009; Etowa, Sethi, & Thompson-Isherwood, 2009; Etowa, Debs-Ivall & Conners, 2015; Hagey et al., 2001; Haslam-Stroud, 2013; King-Jones, 2011). In a study on horizontal violence, King-Jones (2011) states that it is unclear whether IENs who as a group are generally supportive of each other, also contribute to this negative culture because of their

position of power imbalance. Choiniere and MacDonnell (2012) link the direction of healthcare policy reform with the “intensification of nurses’ work and their experience of violence” (p. 66) in the workplace. They provide insights on how policy changes have resulted in managers overseeing more departments, more staff, and needing to be more focused on cost savings, as opposed to offering supportive leadership for their teams (Choiniere & MacDonnell, 2012). Stanley (2012) argues that it is important to rethink of racism as a form of exclusion and seriously pay attention to the underlying problem of the consequences for the individuals who have been affected. When managers are overloaded, alternate mechanisms to listen and dialogue with the person who has experienced the hurt and isolation are equally important as focusing on the unacceptable behaviours of the offender. Healthcare facilities such as this case organization have the challenging dimension of patients and family members exhibiting overt racism who themselves may be extremely marginalized, as well as suffer from cognitive impairments, addictions and/or mental health issues. This makes the case for ongoing supportive leadership by managers even more compelling. Active engagement with staff groups on how differences in backgrounds are not deficits to be overcome but in fact add to the overall capacity of teams to be their best, is needed (Eck, 2015; H. H. The Aga Khan, 2010; Stanley, 2012).

Having discussed the alignment between the guiding concepts and the themes of what an “integrated” IEN is, together with the organizational factors emerging from this research, the remaining key feature of the framework, the two-way process of integration, is discussed next.

7.2.3 Three meanings of “two-way” integration.

The notion of a two-way process of integration as depicted in the guiding framework broadly refers to achievements at both the IEN and organizational levels. The analysis of the findings from this research points to three meanings of two-way integration as summarized in

Figure 16. While the three meanings overlap and are not entirely distinct, there are particular emphases attached to each. The notion of two-way integration as elaborated by other researchers is also referenced wherever appropriate.

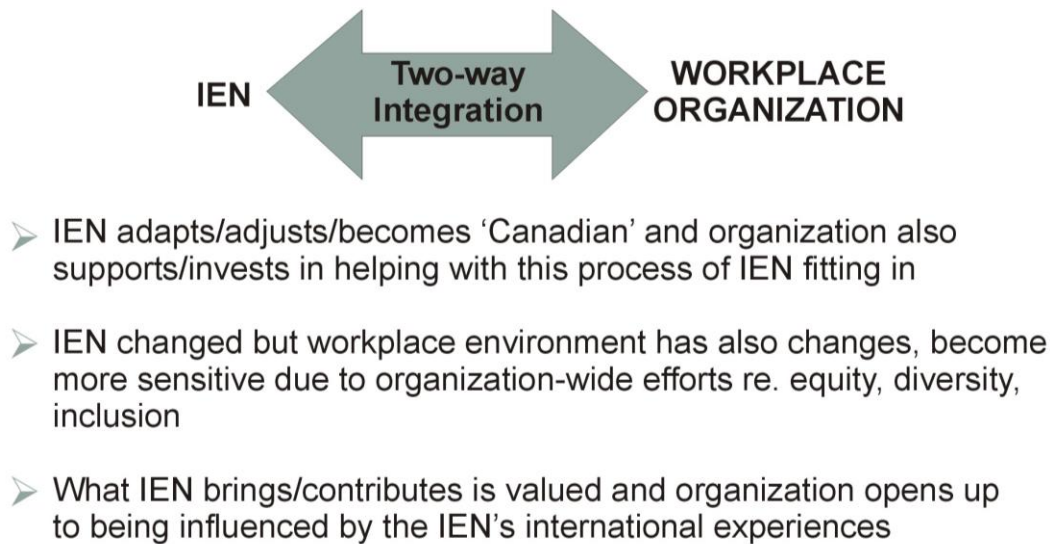


Figure 16 Meanings of Two-way Integration

The first prevalent meaning given to two-way integration refers to when IENs have gone through an intense period of learning and relearning to adapt to nursing practice in Canada and to fit in. Colleagues are welcoming and accepting of the IENs, and the organization is open to providing them with the customized supports they need towards fitting in and being “Canadian nurses”. Understandably, this meaning has some inherent references to the challenges that IENs face when transitioning into the workplace in Canada since, as discussed earlier, for many, integration is “anchored” in the transition phase.

The second meaning refers to the commitment of the employer organization to sustaining an environment conducive to workplace integration. The priorities of workforce diversity, as well as policies that promote equity principles and engagement with the broader community, are

major areas of focus for the leadership's management approach. The diversity in the workforce is valued in the context of the challenges of responding to the needs of a diverse patient population base. IENs' roles as cultural interpreters and knowledge brokers are acknowledged as important two-way processes for colleagues to learn from as part of becoming culturally competent in caring for diverse patients/families. This type of contribution is not credited to IENs alone, but more broadly to a diverse workforce which includes Canadian educated nurses from diverse backgrounds.

The third meaning of two-way integration emerging from this research is the potential for IENs to make a contribution and influence practices based on the expertise they are bringing from having nursed internationally in other healthcare systems. Most IENs have worked in at least one country other than Canada, several have worked in a few different countries before practicing in Canada. Some participants in this research acknowledge the benefits of learning from IENs who have worked in other jurisdictions – both in healthcare systems that are technologically advanced as well as from developing country contexts where IENs have had to nurse with very limited resources.

Interestingly, the IEN participants themselves do not seem to place significant emphasis on how their experiences of having worked in other healthcare systems could be of value to their Canadian colleagues or employer organization. The reasons for this could be at least three-fold: the first reason might be a limitation of this study as the IENs in this research have been working in Canada for an average of 10.9 years and so their international education and work experiences are already quite distant in the past.

The second reason for IENs not emphasizing their international experiences could be the intensity of the transition phase and the major preoccupation for IENs to adjust, adapt and

become “Canadian nurses”. All of the messages from the various points in the broader regulatory system and the workplace have been focused on the IEN fitting in and learning about practicing nursing in Canada. With the priority placed on becoming “Canadian nurses”, IENs are probably left with little or no disposable time or energy to be analytical about the relevance of their international experiences to their Canadian nursing practice.

The third reason is the lack of preparedness for the workplace and teams to be influenced by IENs. It seems that there is no demonstrated interest or appropriate platforms made available for IENs to share about their experiences in a focused manner. Within this type of milieu, where there is no expressed interest on the part of colleagues, not only is the priority on the IEN “fitting in”, but Canadian nursing practice is also seen as the “gold standard” that IENs have to strive for (Etowa, Debs-Ivall & Conners, 2015). This is also supported by Gerrish and Griffith (2003), who find that IENs feel that their colleagues are not interested in the experiences they have come with and this hinders their participation on the team.

In the same UK study mentioned above, senior managers actually think of two-way integration as IENs taking expertise and experiences back to their home countries (Gerrish & Griffith, 2003). Such conditions are ripe for Lukes’s (2005) third dimension or latent power to set in where IENs devalue themselves and their international experiences and believe that the dominant norm is the desirable state. It would seem that while there is the rhetoric of integrated IENs being “Canadian nurses with international experience”, the opportunity to tap into IENs’ international experiences is significantly reduced, if not lost.

To summarize, two-way integration involves a workplace environment which goes beyond supporting IENs to fitting in and being effective in their Canadian nursing practice. It is a context that undergoes change because it has cultivated opportunities for IENs to influence, and

shape, policies, programs and practices (Raguram, 2007). Like in the business/trade sectors, nursing and healthcare could recognize that as immigrants, IENs can be catalysts for innovation and new connections (Parkouda, 2014). The focus does not have to be limited to cultural competency education, but also how the role of cultural and religiously based approaches to healing from international contexts could be incorporated in Canadian practice (Eck, 2015). With the diversity that IENs bring, meaningful dialogue and encounters amongst Canadian nurses would then change Canadian nursing (Etowa, Debs-Ivall & Connors, 2015).

7.3 Emerging Questions

Having revisited the major themes from this research and discussed their alignment with the conceptual dimensions of what is an “integrated” IEN, the organizational factors influencing workplace integration and the meanings of a two-way process of integration, the next sections will discuss the broader questions of: how do expectations surrounding workplace integration of IENs relate to integration of Canadian educated nurses? How does the organizational context influence the workplace integration of IENs differently than the workplace integration of other nurses?

7.3.1 “Integrated” IENs and Canadian educated nurses – do they converge?

The three themes of being a “Canadian nurse with international experience”, progressing on the leadership journey, and persevering with ongoing challenges, jointly comprise an extensive list of expectations surrounding what it means for IENs to be “integrated” in the workplace. From a critical social theory perspective, the natural question which arises is: do the same expectations also apply to workplace “integration” of Canadian educated nurses? In proposing the domains of integration of immigrants and refugees, the CCR (1998) notes that

these measures of integration are against an ideal, and that in order to not violate key principles of freedom and choice, these goals cannot be imposed, especially if the same expectations do not apply to Canadian-born or more established Canadians as well. While participants in this research contributed directly to the meaning of workplace integration of IENs, gaining a similar understanding about workplace integration of Canadian educated nurses is not within the scope of this study. Managers/directors and senior leaders in this research do seem to suggest, however, that the integration goals for IENs are consistent with what the employer expects of *all* its nurses on staff. Nevertheless, the perspectives of Canadian educated nurses about their own integration in the workplace remains limited and can be an area for future research.

Some researchers who have studied the needs of new graduates draw inferences that IENs may require similar transition supports, especially with respect to expectations of fitting into the organizational and team culture and gaining confidence (Baumann, Hunsberger & Crea-Arsenio, 2011). However, it is recognized that IENs are generally experienced nurses and have different realities than recent nursing graduates (Baumann et al., 2012). As was found in this research, once IENs have gone through their transition of “becoming Canadian nurses” and have been functioning as “Canadian nurses with international experience”, there are expectations that they will build on their expertise and progress on their leadership journey.

The theme of progressing on the leadership journey implies that IENs have new reference points at this stage and that they expect to widen the scope of their leadership and influence. Maynard (1999) submits that the shaping of policies and broadening one’s sphere of influence is an expected leadership outcome for all nurses as they advance professionally, and that deliberate development of political influence skills is needed. According to Maynard’s (1999) model for political influence, there are four dimensions to nurses developing and implementing political

influence skills: information, commitment, initiative and involvement. These dimensions are interrelated and would be evident in “integrated” IENs and their experienced colleagues as they go through the phases of exercising political influence. For instance, as they become increasingly aware and informed about the current state of healthcare and nursing practice, “integrated” IENs might critically analyze issues and commit to priorities that are of importance to them. Individually or collectively as part of an organized process, taking initiative to plan concrete steps, including targets for change, would then set the stage for implementing the course of action for political influence (Maynard, 1999). Although leadership involvement and political influence are not necessarily linear processes, they are described progressively in this research and in terms of feedback loops by Maynard (1999). Figure 17 depicts how IENs’ influence widens as they go from providing culturally competent care to patients/families, to mentoring peers/other IENs/new nurses and team leading, to being involved in unit level projects and advanced practice/education/management roles, to participating on organization-wide projects/committees, central/expert resource pools and senior/management roles, to being involved in the nursing profession/system level initiatives externally. At each level, like their experienced colleagues, IENs are exerting their leadership by getting informed, becoming committed to key issues, planning priorities and implementing action plans towards improvements that ultimately impact quality of health outcomes for patients.

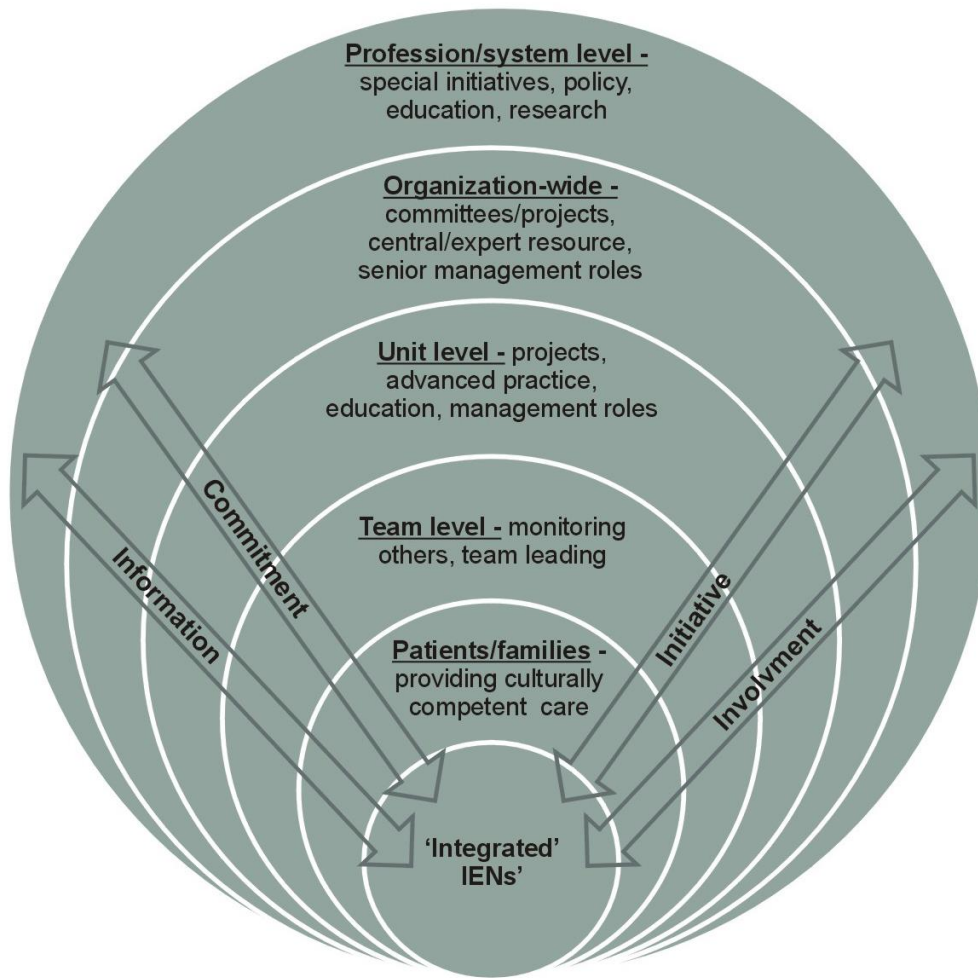


Figure 17 IENs' Widening Scope of Leadership and Influence

Banerjee (2012) states that unlike new arrivals, immigrants who are integrating the workplace shift their comparison group from other immigrants or individuals from the home country, to mainstream colleagues with similar qualifications to themselves. Based on this, it could be argued that at the point of integration, there is a convergence in the goals for IENs and their Canadian educated counterparts. It is important to re-state that the focus of this research is to develop the meaning of an “integrated” IEN in workplace. Comparing this meaning to the

“integration” of Canadian educated nurses or measuring the extent of workplace integration of IENs was not the purpose of this study.

Despite the probable convergence with the integration goals of their Canadian educated counterparts, IENs have differing realities and have to persevere with various challenges even once integrated. Issues of overt racism and perceptions of discrimination in career advancement, have been an emphasis in several other studies as well and need to be addressed (Boateng, 2015; Das Gupta, 2009; Etowa, Sethi, & Thompson-Isherwood, 2009; Etowa, Debs-Ivall & Connors, 2015; Hagey et al., 2001; Haslam-Stroud, 2013; King-Jones, 2011). Banerjee (2012) explains that when immigrants have been in Canada for ten or more years, they begin to have higher expectations of their employment situation, including equitable treatment from managers and co-workers. Galabuzi (2012) submits that employers’ policy commitments to equity are not sufficient and that efforts to measure the outcomes of the policies, both from a quantitative as well as a qualitative perspective, are imperative. Mechanisms to measure “integration” for all nurses would allow committed employers to ensure that IENs are achieving equitable outcomes and not being “pushed to the margins” (Caidi & Allard, 2005, p. 1).

7.3.2 Workplace influence on IENs’ integration – how distinct is it?

In understanding what is different about how the organizational context influences integration of IENs as opposed to their Canadian educated colleagues, three major considerations have emerged: the overwhelming transition phase, racialization and resilience.

The transition phase of adapting into the workplace and “becoming a Canadian nurse” seems to leave a prominent mark in the memories of IENs as well as others who work alongside and support them. For IENs, transitioning into the workplace builds from the stresses of the prior phases of migrating, navigating through the regulatory process, and meeting the rigorous

requirements even before being allowed entry into the profession. According to Boateng (2015), Canadian born and educated nurses' routes into the profession are generally much shorter, faster and less costly than what IENs have to endure. Aside from overcoming the numerous hurdles in order to enter the profession, various studies document the effects of deskilling and devaluing on IENs, especially when there are prolonged gaps or periods of not being able to practice nursing (Blythe & Baumann, 2009, Kolawole, 2009; Newton, Pillay & Higginbottom, 2012). Once IENs find nursing employment, the intensity of the learning and adjustment during the transition phase is still dependant on several factors such as: previous exposure to the English language, western concepts and philosophies of nursing, individualistic and self-promoting orientations and consumerist cultures, to name a few. Issues of self-esteem and overall confidence can be further exacerbated for IENs in environments where there is lack of tolerance, disrespect, bullying and "othering" by senior and more established nurses (King-Jones, 2011).

As indicated earlier, transition experiences of IENs are often compared to those of new graduates (Baumann, Hunsberger & Crea-Arsenio, 2011). Yet it may be argued that, given the unlearning and relearning that IENs may have to undergo in order to be adequately socialized in Canadian nursing (Neiterman & Bourgeault, 2015), the length of the transition phase for some IENs could be even longer than for new Canadian-educated graduates. This is ironic as IENs generally come with more years of experience and diverse expertise from having practiced in international contexts. The need to shorten the transition phase and speed up integration is compelling. Extended and customized IEN-specific orientation supports (Baumann et al., 2012; Khalili et al., 2015; Zizzo & Xu, 2009), coupled with organization-wide efforts towards diverse, inclusive and equitable work environments, can help reduce the overwhelming effects of the transition phase.

The second consideration in how the organizational context influences integration of IENs differently than other nurses has to do with the fact that the majority of IENs who have entered the profession in Canada over the last two decades, are non-white, racialized women (CIC, 2012). Stanley (2012) defines racialization as “the social process of categorizing people by race” and that racism is when such organizing leads to exclusions that have significant negative consequences for the excluded (p. 53). The racist experiences described by IENs in this research suggest that IENs are not a homogenous group and that White IENs may be influenced by the workplace context differently than racialized IENs. Studies on racism in nursing do not differentiate experiences of racialized nurses based on where they are educated (Boateng, 2015; Das Gupta, 2009; Etowa, Sethi, & Thompson-Isherwood, 2009; Etowa, Debs-Ivall & Conners, 2015; Hagey et al., 2001; Haslam-Stroud, 2013; King-Jones, 2011). In other words, when it comes to individual acts of racism and abuse from patients/families and colleagues, or institutional racism resulting in exclusions from career advancing activities, racialized IENs may have experiences that are different than their White IEN counterparts.

At the same time, racialized IENs’ experiences may be more in common with their racialized Canadian educated peers. Boateng (2015) finds that visible minority nurses experience verbally aggressive behaviours from patients more frequently relative to White nurses. Several researchers find that Black nurses who are more qualified than their White colleagues need to work harder to get promoted to the same level (Alexis & Vydelingum, 2007; Das Gupta, 2009; Etowa, 2007; Etowa et al., 2009). Larsen (2007) highlights gender differences in how racialized IENs deal with discrimination in career progression where men are more likely to move and look for alternate environments whereas women give up on pursuing their aspirations more easily.

Likupe (2008) cautions that a lack of a deeper gender based analysis of the types of coping strategies encountered with racism can further victimize racialized female IENs.

Workplaces, such as the case organization, have taken some concrete steps to try and counter the effects of racism for racialized nurses, including IENs, but ongoing and deliberate efforts are necessary. Implementing best practice guidelines for managing workplace violence and embracing cultural diversity to develop cultural competence are key elements of the case organization's broader commitment to equity, diversity and inclusion. Specific references to the diverse workforce, protocols for dealing with problem behaviours and the active support from colleagues, were readily shared by IEN participants in this study. This is an impressive achievement. However persistent efforts for lasting effects are required. As discussed earlier, aside from the focus on the offensive behaviours and the offender, there is also an important role for frontline managers and other leaders to actively engage and dialogue with nurses who have been negatively affected by racism.

Some experts argue that within the Canadian milieu, we still like to believe that we live in a perfect multicultural society, and racism is often viewed as individual acts or exceptions on the part of a few people (Stanley, 2012; Weiner, 2012). There are concerns about how "white privilege" remains unacknowledged by most and in turn becomes the unconscious oppression embedded in our systems (McGibbon & Etowa, 2009; McIntosh, 1990). This structured racialized exclusion systematically favours Whiteness as normative and desirable (McGibbon & Etowa, 2009; McIntosh, 1990). At the case organization, the leadership commitment and policies promoting equity principles have the aim of addressing systemic issues which could result in institutional barriers or exclusions for racialized staff as well as patients/families. Again, the case organization's achievements are commendable and deserving of the various awards and

recognition it has received. While some specific issues needing focused attention have emerged, perhaps the most encompassing recommendation is to establish accountability systems to measure workplace integration, and track for equitable outcomes based on gender and race of IENs and other nurses. Sustaining an organizational culture which is inclusive and thoughtful about equity encourages its diverse stakeholders to push the boundaries beyond tolerating each other to a pluralist approach where there is recognition of everyone's shared values as well as distinct identities (Eck, 2015; H. H. The Aga Khan, 2015). In this context, the need for IENs to have diverse social networks as well as active connections with other colleagues from similar experiences and/or linguistic and cultural backgrounds is normalized if not encouraged, so that IENs can build community and resilience as individuals and as a group.

Finally, the third consideration of how the workplace context affects integration of IENs differently than other nurses has to do with the IENs' resilience. Resilience refers to "the ability for an individual to adjust to adversity, maintain equilibrium, retain some sense of control over their environment and continue to move on in a positive direction" (Jackson, Firtko & Edenborough, 2007, p. 3). For some time now, workplace adversity and resilience have been discussed in nursing, especially in relation to the impact of healthcare reforms on nurses' workloads and their loss of control (Jackson et al., 2007). Adding to this, resilience has emerged in the literature on racism in nursing (Etowa, 2007; Etowa et al., 2009; Etowa, Debs-Ivall & Conners, 2015) and experiences of IENs (Njie-M, 2015; St. Pierre et al., 2015). Giordano (1997) lists qualities associated with resilience to include: resourcefulness, self-confidence, curiosity, flexibility, level-headedness, self-discipline, problem-solving and emotional stamina. These bode well when considering the adverse circumstances that IENs have had to endure. Given their life experiences to begin with, as well as the processes of migrating (for many, more than once

before coming to Canada), surviving the turmoil of entering the profession and transitioning into the workplace, IENs have demonstrated much resilience. In this research, participants note that the resiliency of IENs makes them important assets to the organization. One participant states how IENs' cumulative experiences in dealing with change make them "experts at transitions" (participant I023). Another proudly states said that her employers know that she has learned to "do a lot with very little" (participant I027).

While the resilience that IENs have developed by the time they are in the integration phase is noteworthy, employers cannot become complacent about the ongoing challenges that could pose risks and heighten IENs' vulnerabilities. For communities who are at risk of racism, helpful strategies to teach and sustain resilience have focused on negotiation skills, positive group identification and social support (McKenzie, 2015). Jackson et al. (2007) state that resilience-building strategies for nurses can be promoted by workplaces through the nurturing of positive professional relationships, encouraging life balance and spirituality, developing emotional insight and encouraging reflectivity and mentoring programs. In this research, IENs placed emphasis on the enjoyment and support gained through camaraderie with other nurses originating from the same country or of similar linguistic and cultural backgrounds. Workplace organizations can engage in meaningful dialogue with IENs about mechanisms to promote a greater connection and sense of community among colleagues with similar experiences, and/or any other ways of fostering their resilience.

In summary, the workplace context affects IENs in distinct ways but there are also some commonalities with other groups of nurses. The overwhelming effects of the transition period have some commonalities with new Canadian educated graduates, but IENs also have different levels of readiness and specific customized supports are needed. Racialization has a bearing on

the majority of IENs, but the exclusions and consequences that stem from it are also shared with racialized Canadian educated nurses. The organization's commitment to and investment in strategies to promote equity, diversity and inclusion, is an essential building block for integration of all nurses. While a comparison of qualities of resilience between IENs and their Canadian educated colleagues has not been done, and is not a focus of this study, it is suggested that through their cumulative experience with adverse circumstances, IENs build much resilience. However, the perseverance required in dealing with ongoing challenges could result in an erosion of this resilience. Workplace contexts committed to IEN integration should involve IENs in developing resilience-strengthening strategies.

7.4 Strengths and Limitations of this Research

Having SMH as the case organization for this study is a major strength of my research. As an exceptional case, SMH offers many lessons from its long history of recruitment and retention of IENs within a broad based context of organizational efforts towards equity, diversity and inclusion.

The snowballing technique of recruiting participants through mutual colleagues of participants was generally effective. While snowball sample would not be considered to be representative of the study population, in this qualitative study, the goal was to maximize variation in the sample so that the diversity of their experiences could be understood. The resulting total sample of twenty-eight where at least fifty per cent of the participants were IENs, was a strength. The IENs were from diverse backgrounds and two were male, perspectives of IENs originating from the Indian and African sub-continent were missing. It is possible that IENs from these backgrounds would have had different perceptions. Also, all of the IEN

participants were RNs, since the case organization does not employ nurses in the RPN category. IENs who were RPNs could have provided additional insights about workplace integration of IENs. From an organizational standpoint, stakeholders who shared their perspectives were from different vantage points, ranging from peers/mentors, managers/directors to senior leaders. Even though corporate level representatives were included, the lack of direct participation from the HR department is noted as they could have added key insights about recruitment and retention efforts.

The strength of this study is also evident in the methodological rigour applied in its implementation. Credibility, transferability and confirmability were three major criteria. A preliminary analysis of study findings was presented to participants prior to focus group discussions. The focus group discussions served as a form of member checking as well as adhered to the spirit of critical social theory where research participants assist in deepening the analysis. Data triangulation through within and across case analysis of data from interviews with participants, review of documents and focus group discussions strengthens the credibility. Regular debriefings with my research director and thesis committee have been important.

Finally, this research is an instrumental case study involving a single organization within a specific community context. The fact that this study involved only one organization could be seen as a limitation, although the learning derived from this single case study site is a foundational work and may lead to a program of research with multiple sites. The use of SMH as an exceptional case may also be seen as a limitation especially if one is interested in a deeper understanding of how social closure operates to exclude IENs from organizational processes. A thick description of the organizational context has been provided so that the reader who is interested can reach a conclusion about transferability to another similar situation.

7.5 Implications for Practice, Policy, Education and Research

Findings and analysis from this research will be presented to the nursing leadership at the case organization. A potential outcome might be an action agenda for the case organization to pursue beyond my involvement as the researcher. The understanding of workplace integration of IENs gained from this research has implications for other audiences as well: nursing employers and IENs in practice settings; policy makers, regulators and funders in the policy arena; educators in academic institutions; and researchers committed to advancing the cause of IENs' integration into Canadian nursing.

7.5.1 Implications for practice - nursing employers and IENs.

Employers' commitment to healthy work environments for nurses and quality of care for an increasingly diverse patient population warrants an active interest in facilitating workplace integration of IENs. Workplaces can consider the final conceptual framework when establishing a deliberate organization-wide change process to promote equity, diversity and inclusion. This research also points to broader benefits from employers' investments towards IENs. "Integration" of IENs may have similarities with needs of their Canadian educated colleagues, including those who are also racialized.

The specific meanings of what "integrated" IENs are, and the organizational factors identified in this research and summarized in Figure 11, can be examined within their workplace context to determine transferability. Delineating the initial phase of transitioning into the nursing workplace from the longer term integration process highlights how IENs develop the identity of a "Canadian nurse" but with the added dimension of bringing international experience to their practice. As what might be expected of their Canadian educated colleagues who are

experienced, “integrated” IENs also have aspirations of progressing on their leadership journey. Specific challenges and exclusionary practices affecting IENs and other racialized staff have to be addressed on an ongoing basis through policy and practice changes. Embedding workplace integration of IENs as a strategic priority in the organization’s plan, as well as establishing the corporate champion(s) and accountability mechanisms, should ensure a sustained focus. Based on an organizational self-assessment, employers can develop an action plan and set targets for change in the areas of organization-wide leadership commitment to equity, workforce diversity, policies promoting equity principles and engagement with the broader community.

Employers can be cautious about particular pitfalls identified through this research. Lack of clearly demonstrated commitment from senior leaders, coupled with only sporadic initiatives or special “diversity management” projects sends the wrong signals to managers and staff at other levels in the organization. Missing opportunities in making deliberate connections between the core business of delivering quality care and the recruitment and retention of a diverse, competent nursing workforce, is problematic. Any organizational efforts towards promoting inclusion could be misinterpreted or seen as “tokenistic”. In the absence of a systematic, organization-wide, planned and resourced process, there is only wavering commitment whereby “differences” in backgrounds and experiences are only tolerated and specific initiatives to support IENs may be seen as “add-ons”, reserved for only when and if time and resources permit.

The type of leadership and workload of frontline managers is critical to integration of IENs and requires a focus in the practice setting. Leadership education for nurses and managers to understand and apply the concept of equity cannot be overemphasized. Implementation of relevant best practice guidelines such as the ones developed by RNAO, namely *Embracing*

cultural diversity to develop cultural competence and *Managing violence in the workplace* may lend direction and pertinent resources to nurse managers and nurses. Nurse managers' focused attention to professional development and career advancing activities can facilitate IENs' progress on their leadership journey. A conscious shift to valuing IENs' international experiences and diverse perspectives as opportunities for innovation should result in greater responsiveness to needs of patients and the broader community.

IENs can take solace in the fact that while the intensity of the transition phase may appear to discount the nursing expertise and experiences they have come with, they will find a heightened receptivity in their colleagues as they integrate and are viewed as "Canadian nurses with international experiences". Active pursuit of professional and leadership development will provide additional tools to influence and shape practices in their workplaces and beyond. Keeping a reflective journal comparing and contrasting nursing practices in the various environments where they have worked may be a valuable analysis to share with Canadian educated colleagues within the workplace and more broadly within the profession. Embracing the Canadian value of the "respect for difference as well as the right to be different" (Ley, 2005) is important as "integrated" IENs confidently advocate for their patients/families, as well as themselves.

7.5.2 Implications for policy - policy makers, regulators and funders.

Policy makers, regulators and funders have an important role in acknowledging the contributions that IENs are making in sustaining the profession as well as changing the face of nursing to reflect the diversity of Canada's population. Implementing mechanisms to engage and dialogue with IENs in developing solutions to solve problems facing the Canadian healthcare

system and the nursing profession are warranted. Strategies that include IENs' presence at policy tables would reflect Canadian nursing's humility and openness to learning from international contexts. Such efforts in valuing IENs' international experiences may begin to change the tone at the system level and within the nursing community at large, including providing positive reinforcement for employers' efforts to facilitate workplace integration. Funders and policy makers can also support the development of resources for employers who need tools to facilitate equitable outcomes and measure the workplace integration of IENs.

Recognizing the relationship of the integration phase with the earlier transition process can facilitate in appropriate policy development, as well as the appropriate allocation of resources for supporting IENs and their employers. The costs and intensity of the earlier phases of integration is a compelling case for policy makers, especially regulators, to develop interventions to accelerate the transitions for IENs. Again, meaningful engagement and dialogue with IENs, along with consultations with regulators from other international jurisdictions, has the potential for novel solutions.

7.5.3 Implications for educators.

Educators have the unique role of supporting nursing students, practicing nurses and IENs alike, to safely engage in critical analysis about complex healthcare and nursing issues. Creating platforms for meaningful encounters between IENs and domestic students should serve to produce lasting effects and relationships. This research points to several content areas that warrant early and repeated emphases in nurses' education to have positive effects not just on IENs, but all nurses. Focused attention on the concepts of equity (and equality), diversity and inclusion cannot be overemphasized. Use of case studies to practice applying the equity lens to patient related scenarios as well as nursing workforce situations can help make the connection

between healthy work environments for nurses and quality of care for patients. Leadership education and deliberateness in the teaching/learning of political influence skills for IENs and other students, are especially relevant for their role in shaping practices and systems.

7.5.4 Implications for researchers.

Researchers have an opportunity to enter into a critical discourse that profiles contributions that IENs make as they integrate into the profession. By shifting the paradigm away from a deficit orientation to IENs being seen as assets, researchers can assist in ensuring that IENs achieve equitable outcomes in terms of practicing as “Canadian nurses with international experience” as well as progressing on their leadership journey in nursing. Further work is required in operationalizing the definition of workplace integration of IENs developed through this research. Measurement tools to assess integration of IENs as well as organizational facilitators can be helpful in establishing benchmarks and for purposes of comparisons at various levels, including workplaces, healthcare sectors and geographic communities. Lastly, researchers can conduct critical analyses of international experiences of IENs to identify lessons that can be incorporated into nursing and healthcare practices in Canada.

7.6 Conclusion

Using a qualitative case study approach informed by critical social theory, this research has addressed gaps in nursing knowledge by offering a definition of workplace integration of IENs based on the perspectives of IENs and other stakeholders. While a significant amount of research on IENs exists, it primarily focuses on the early phases of navigating through the regulatory process, orientation to Canadian nursing, and transitioning into the workplace. IENs are problematized and there is a heavy one-sided emphasis on what IENs need to do to become “Canadian nurses” and “fit in”. This research shifts the focus to IENs who are in a later, post-

transition phase and clarifies workplace integration as a “two-way” process to include how the employer organization influences the integration of IENs.

The two-way notion of workplace integration resulting in transformations at the levels of the individual IEN, as well as the organization, is synchronous with critical social theorists’ plea for nursing to critically examine sociopolitical structures and advocate for changes that shift power, leading to equitable outcomes for marginalized groups. This outlook is well overdue in the context of IENs as an equity-seeking group of nurses. Healthy workplaces for all nurses, including IENs, result in quality nursing care and better outcomes for patients.

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Appendix I – Indicators of Transition & Integration According to Domains for IENs

Dimension	Short-term (adaptation/ transition)	Longer term (integration)
Economic	• <i>Nursing employment</i> • <i>Self-sufficiency</i>	• <i>Mobility</i> • <i>Income Equality</i> • <i>Progression in Nursing</i>
Social	• <i>Diverse social network</i>	• <i>Capacity to access & influence: team, workplace, practice</i>
Cultural	• <i>Adapting to dominant nursing culture & role</i>	• <i>Redefining one's identity & values</i>
Political	• <i>Awareness of processes/ structures influencing nursing</i>	• <i>Full participation in structures & movements</i>

(Adapted for IENs from CCR, 1998)

Appendix II - Nussbaum's Framework of Inquiry

Nussbaum's (2005) questions facilitate CST inquiry within the organizational context - focus is on issues of Resources, Hierarchy and Policies. The questions to stimulate thinking from a CST perspective:

Resources – Which resources, if any, are taken for granted? By whom? Who controls the resources? Who needs them? According to which and who criteria of need? To what extent do varied capabilities enter the discussion? Are resources available? If so, to whom? How, if at all, are resources shared, hoarded, concealed or distributed? What are the implications of having control over resources and of handling them?

Hierarchies – What are they? How did they evolve? At what costs and benefits to involved actors? Who benefits from them? Under which conditions? How are the hierarchies related to power and oppression? How, if at all, do definitions of race, class, gender and age cluster at specific hierarchical levels? Which moral justifications support the observed hierarchies? Who promulgates these justifications? How do they circulate? How do these hierarchies affect social actions at macro, meso and micro social levels? How and when do the hierarchies change?

Policies and practices – what are the rules – both tacit and explicit? Who writes or enforces them? How? Whose interests do the rules reflect? From whose standpoint? Do the rules and routine practices negatively affect certain groups or categories of individuals? If so, are they aware of them? What are the implications of their relative awareness or lack of it? To what extent and when do various participants support the rules and policies and practices that flow from them? When are they contested? When do they meet resistance? Who resists and which risks might resistance pose?

Appendix III - Recruitment for Interviews Information Letter

Introduction to the Study

Title: Beyond Transition: Workplace Integration of Internationally Educated Nurses – A Qualitative Case Study Approach

Did you obtain your nursing education outside of Canada?

Are you an internationally educated nurse with at least 5 years of experience in Canada?

Are you a Canadian educated nurse who has worked with internationally educated nurses?

If yes, we would like your help in understanding the experiences and aspirations of internationally educated nurses who have already adapted to Canadian nursing.

This research project's main aim is to understand what 'workplace integration' actually means and how it is achieved – both from the perspectives of internationally educated nurses and the colleagues they work with.

This research will help fill a knowledge gap about how nursing envisions internationally educated nurses' aspirations beyond the early transition phase and how employers may facilitate the achievement of the goals of integration.

You would be asked to meet with me for an in-person confidential interview lasting 1 to 1 ½ hours. The interview can be arranged for a mutually convenient time and in a quiet and comfortable space. At the outset, you will be asked to provide consent and complete a brief form providing demographic information about you.

To acknowledge your participation in the interview, you will be provided with a \$25 gift card.

Once the data collection process has been completed, you will be invited to a group session where the key findings and preliminary analysis will be presented and discussed. You will have an opportunity to provide any further insights you have, including recommendations for how workplace integration for internationally educated nurses should be thought of and how it can be achieved.

If you are interested, please contact me directly at my telephone number or email address.

Sincerely,
Zubeida Ramji, BSN, MHSc, PhD Candidate
University of Ottawa


Appendix IV - Recruitment Poster

Post until: March 31, 2015

REB# 14-168

BEYOND TRANSITION: WORKPLACE INTEGRATION OF INTERNATIONALLY EDUCATED NURSES

NURSING RESEARCH

Are you an internationally educated nurse with at least five years of
experience in Canada?

OR

Are you a Canadian educated nurse who has worked with internationally
educated nurses?

GET INVOLVED AND SHARE YOUR EXPERIENCES

What: Individual interview with RNs and NPs (60-90 minutes)

- Share your experiences and aspirations for workplace integration of internationally educated nurses who have already adapted to Canadian nursing
- Tell us what you think would help achieve the goals of workplace integration of internationally educated nurses

Compensation: \$25 gift/honorarium

Please contact Zubeida Ramji [REDACTED] or [REDACTED] for
more information

Note: Participation will be based on meeting study criteria and recruitment
will continue until no new information is generated.



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Appendix V – Email Script for Recruitment of Managers/Leaders

Date

Subject: Request for participation in research study '*Beyond Transition: Workplace Integration of Internationally Educated Nurses – A Qualitative Case Study Approach*'

Dear (name of manager/leader):

I am writing to request your participation in this PhD research which has the main aim of understanding what 'workplace integration' actually means in the context of internationally educated nurses (IENs) and how it is achieved. This research will help fill a knowledge gap about how nursing envisions IENs' aspirations beyond the early transition phase and how employers may facilitate the achievement of the goals of integration.

In addition to IENs who have been working in Canada for at least 5 years, their nurse colleagues, educators, preceptors and managers are also being recruited for the sample. As a leader at St. Michael's hospital, your perspectives are important and will be most valuable to incorporate in this study.

Can I please meet with you in-person for a confidential interview lasting 60 – 90 minutes? I am available on: _____ (options for dates/times). I can meet you in a quiet and comfortable space of your preference.

At the outset, you will need to provide consent and complete a brief form providing demographic information about you. Both of these documents are attached for your review in advance.

Once the data collection process has been completed, you will be invited to a group session where the key findings and preliminary analysis will be presented and discussed. You will have an opportunity to provide any further insights you have, including recommendations for how workplace integration for internationally educated nurses should be thought of and how it can be achieved.

I look forward to hearing from you soon.

Sincerely,

Zubeida Ramji, BSN, MHSc, PhD Candidate
University of Ottawa

[Redacted Signature]

Appendix VI – Interview Guides

Interview Questions – IENs

Question #1

As an IEN who has been working in Canada for over 5 years, how would you describe your current stage of development professionally, as a nurse?

- What are your hopes and aspirations?
- What are the opportunities for you to fulfill these?
- What are the challenges or barriers that will be in the way?

Question #2

There are many Government programs and organizational initiatives that are designed to help internationally educated professionals to ‘integrate’ into their profession and in their workplaces. However, ‘integration’ has not been defined clearly.

- How would you think about integration?
- What does integration mean to you as an IEN?
- How do you define integration?

Question #3

Given the priority your organization has given to recruitment and retention of IENs, how ‘integrated’ do you feel in your workplace?

- What are you feeling, sensing, experiencing within your organization that is influencing your rating?

Question #4

What are the initiatives that your organization has/is undertaking to facilitate integration of IENs?

- What are the things your organization is doing or not doing that hinders integration?

Question #5

What types of supports does your organization need to deal with any challenges that continue to exist with integration of IENs?

- What type of expertise is needed...? or resources?...or mandate?

Question #6

What are some ways in which the focus on IENs has benefited other nurses overall?

Question #7

How has your organization’s priority on IEN integration impacted quality of care?

Question #8

What are some other perspectives or understandings regarding integration of IENs that I have not addressed, that you would like to share with me?

Interview Questions – Non-IEN Peers

Question #1

There are many Government programs and organizational initiatives that are designed to help internationally educated professionals to integrate into their profession and in their workplaces. How would you think about integration?

- How do you define integration?
- What does integration of IENs mean to you?

Question #2

Given the priority your organization has given to recruitment and retention of IENs, how integrated do you feel IENs are in your workplace?

- What you are seeing, hearing or feeling within your organization that is influencing your rating?

Question #3

What are the initiatives that your organization has/is undertaking to facilitate integration of IENs?

- What are the things your organization is doing or not doing that hinders integration?

Question #4

What types of supports does your organization need to deal with any challenges that continue to exist with integration of IENs?

- What type of expertise is needed...? or resources? ...or mandate?
- What are some ways in which the focus on IENs has benefited other nurses overall?
- How has your organization's priority on IEN integration impacted quality of care?

Question #5

What are some other perspectives or understandings regarding integration of IENs that I have not addressed that you would like to share with me?

Interview Questions – Nurse Managers/Leaders**Question #1**

There is currently within the labour market the notion of 'integration into the workplace'. How do you understand integration of workers, specifically IENs in the workplace?

- What does it mean to you when you hear that or when you might be talking about that in your organizations?
- How would you define integration?
- What does integration of IENs mean to you?

Question #2

Given the priority your organization has given to recruitment and retention of IENs, how integrated do you feel IENs are in your workplace?

- What you are seeing, hearing or feeling within your organization that is influencing your rating?

Question #3

What are the initiatives that your organization has/is undertaking to facilitate integration of IENs?

- What are the things your organization is doing or not doing that hinders integration?

Question #4

What types of supports does your organization need to deal with any challenges that continue to exist with integration of IENs?

- What type of expertise is needed...? or resources? ...or mandate?

Question #5

Can you please describe the key elements of your larger plan to be committed to integration of IENs in your organization?

- Which of the elements are you happy about in terms of achieving the desired outcomes?
- What is not working out as well?
- What are some ways in which the focus on IENs has benefited other nurses overall?
- How has your organization's priority on IEN integration impacted quality of care?

Appendix VII – Contact Summary Form

Contact Summary Form

Adapted from Miles & Huberman (1994, p. 53)

Contact Type: Visit _____ Phone _____ With Whom: _____	Contact Date: _____ Today's Date: _____
<u>What were the main issues or themes that struck you in this contact?</u> 	<i>Codes</i>
<u>Summarize the information you got (or failed to get) on each of the target questions you had for this contact:</u> <u>Question #1</u> <u>Question #2</u> <u>Question #3</u>	<i>Codes</i>
<u>Any salient, interesting, illuminating aspects of this contact?</u> 	<i>Codes</i>
<u>What new (or remaining) target questions do you have in considering the next contact with the case organization?</u> 	<i>Codes</i>

Appendix VIII - Socio-demographic Questionnaire

SOCIO-DEMOGRAPHIC QUESTIONNAIRE

1. What is your gender?
Male ____ Female ____ Transgendered ____
2. What is your age? ____ years old
3. What is your country of origin? _____
4. What is your racial background? _____
5. What languages do you speak (other than English)? _____
6. What is your religious affiliation (if you have one)? _____
7. What year did you immigrate to Canada? _____
8. Were you recruited overseas as a nurse by a Canadian employer?
____ Yes ____ No
9. What is your current immigration status?
____ Citizen
____ Permanent Resident
____ Refugee/ Refugee Claimant
____ Temporary Work Visa
10. Did your family accompany you at the time of immigrating to Canada?
____ Yes If yes, who? _____ (provide detail please)
____ No
11. Are you married?
____ Yes ____ No
12. Do you have children or dependants?
____ Yes If yes, how many and what age? _____
____ No

NURSING BEFORE COMING TO ONTARIO/CANADA

13. Which country did you obtain your original nursing education in? _____
14. What year did you graduate from nursing school? _____

15. What language was your nursing education provided in? _____

16. What type of nursing did you do before coming to Canada? (midwifery, medical, etc.)

17. How many years did you work as a nurse before coming to Ontario/Canada? _____

NURSING IN ONTARIO

18. What category of nursing registration do you have?

___ RPN

___ RN

___ NP

19. How many years have you worked as a nurse:

In Canada? _____ In Ontario? _____ At St. Michael's Hospital? _____

20. What type of nursing do you do at present (midwifery, medical, etc.)?

21. Do you work full time?

Yes _____

No _____ If no, how many hours do you work each week? _____

22. What is your job title at present? _____

THANK YOU FOR YOUR INFORMATION!

Appendix IX– Focus Group Information Sheet

Title: Beyond Transition: Workplace Integration of Internationally Educated Nurses – A Qualitative Case Study Approach

This research project's main aim is to understand what 'workplace integration' actually means and how it is achieved – both from the perspectives of internationally educated nurses and the colleagues they work with. This research will help fill a knowledge gap about how nursing envisions internationally educated nurses' aspirations beyond the early transition phase and how employers may facilitate the achievement of the goals of integration.

The data collection process has been completed. A total of ____ (#) participants were individually interviewed and ____ (#) organizational documents were reviewed. Thank you for your participation.

At this stage, you are being invited to a group session along with _____ (# and description of other participants). At the focus group session, key findings and preliminary analysis of the data will be presented first and then a facilitated discussion will follow. You will have an opportunity to provide any further insights you have, including recommendations for how workplace integration for internationally educated nurses should be thought of and how it can be achieved.

The focus group will take place on:

_____ (date and time)

At _____ (venue)

At the outset, you will have an opportunity to ask any questions before providing consent.

Light refreshments will be provided.

Please confirm that you will be attending by contacting me directly at my telephone number or email address.

Sincerely,

Zubeida Ramji, BSN, MHSc, PhD Candidate
University of Ottawa

[Redacted Signature]

Appendix X – Focus Group Guide

Preamble:

We are conducting focus group discussions as a follow up with all of the staff at the hospital who participated in the research study “Beyond Transition: Workplace Integration of Internationally Educated Nurses – A Qualitative Case Study”. Now that the data collection based on __(#) individual interviews and review of __(#) organizational documents has been completed, the purpose today is to review the findings and preliminary analysis with you, followed by a focused discussion on further insights and recommendations that you might have. This focus group should take no more than 90 minutes, but we would like everyone to have the chance to give their opinion.

Before beginning our conversation, we would like you to review the information sheet and consent form provided, ask any questions you might have about the focus groups, and sign the form if you feel comfortable in participating in the focus group.

Presentation of Key Findings & Preliminary Analysis: 15-20-minute power point - TBD

Discussion Questions:

1. What is your overall reaction to the findings from this research?
[Probes: What resonates for you? What surprises you?]
2. When you listen to what has emerged in terms of specifics about the concept of ‘workplace integration for IENs’, how is this same or different from what you had imagined?
[Probes: Does it make sense to you? Is there anything missing? What further/new questions arise for you?]
3. What about the findings and analysis related to organizational factors that influence workplace integration for IENs – what is your reaction to what has emerged in this study?
[Probes: Are there additional factors that facilitate workplace integration? What about factors that inhibit integration or create barriers?]
4. With respect to recommendations, do they cover the main areas you would want highlighted?
[Probes: What additional recommendations would you want included? Are there any that you are questioning/wondering about their relevance?]
5. What additional questions has this research raised for you?
[Probe: If there was an opportunity to do more research on IENs who are ‘post-transition’, what do you think would be important to focus on? What are some research priorities in the area of workplace integration for IENs?]

Appendix XI – University of Ottawa Ethics Approval Notice

File Number: H02-14-05

Date (mm/dd/yyyy): 08/12/2014



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
Zubeida	Ramji	Health Sciences / Nursing	Student Researcher

File Number: H02-14-05

Type of Project: PhD Thesis

Title: Beyond Transition: Workplace Integration of International Educated Nurses-A Qualitative Case Study

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
08/12/2014	08/11/2015	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:
N/A



Université d'Ottawa **University of Ottawa**
Bureau d'éthique et d'intégrité de la recherche 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 (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (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, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the "Modification to research project" form available at: <http://www.research.uottawa.ca/ethics/forms.html>.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents 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 at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

Kim Thompson
Protocol Officer for Ethics in Research
For Daniel Lagarec, Chair of the Health Sciences and Sciences REB

Appendix XII– University of Ottawa Ethics Renewal Notice

File Number: H02-14-05

Date (mm/dd/yyyy): 07/06/2015



Université d'Ottawa **University of Ottawa**
Bureau d'éthique et d'intégrité de la recherche 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 / Nursingy	Supervisor
Zubeida	Ramji	Health Sciences / Nursingy	Student Researcher

File Number: H02-14-05

Type of Project: PhD Thesis

Title: Beyond Transition: Workplace Integration of International Educated Nurses-A Qualitative Case Study

Renewal Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
08/12/2015	08/11/2016	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 (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (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, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the "Modification to research project" form available at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: <http://research.uottawa.ca/ethics/submissions-and-reviews>.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature:

Jasmine Sarazin
Ethics Coordinator
For Catherine Paquet, Director of the Office of Research Ethics and Integrity

Appendix XIII – SMH Ethics Board Approval

Research Ethics Office
Telephone: (416) 864-6060 Ext. 2557
Facsimile: (416) 864-6043
E-mail: realeth@smh.toronto.on.ca

St. Michael's
Inspired Care.
Inspiring Science.

August 1, 2014

Dr. Lianne Jeffs,
Department of Nursing,
St Michael's Hospital

Dear Dr. Jeffs,

Re: REB# 14-168^C - Beyond Transition: Workplace Integration of Internationally Educated Nurses: A Qualitative Case Study

REB APPROVAL:	Original Approval Date	August 01, 2014
	Annual/Interval Review Date	

Thank you for your application submitted on **22 May, 2014**. The above noted study has been reviewed through a delegated process (not by Full Board review). The views of the St. Michael's Hospital (SMH) Research Ethics Board (REB) have been documented and resolved. Please note that no member of the St. Michael's Hospital Research Ethics Board associated with this study was involved in its review or approval.

The REB approves the study as it is found to comply with relevant research ethics guidelines, as well as the Ontario Personal Health Information Protection Act (PHIPA), 2004. The REB hereby issues approval for the above named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review of REB approval. In addition, the following documents have been reviewed and are hereby approved:

1. Protocol – ver: 1 dated March 2014
2. Poster/Advertisement ver: 2
3. Letter of Information for Canadian and IE Nurses ver: 2
4. Letter of Information for Nursing Managers/Leaders ver: 2
5. Focus Group Information Sheet ver: 2
6. Consent Form for Interview ver: 2
7. Consent Form for Focus Group ver: 2

Furthermore, the following documents have been received and are acknowledged:

8. Interview Guides - ver: 1
9. Sociodemographic Questionnaire - IENs ver: 2
10. Sociodemographic Questionnaire - Non-IENs ver: 1
11. Contact Summary Form ver: 1
12. Focus Group Guide ver: 1
13. Document Review Approval Form ver: 1
14. Honorarium Receipt ver: 1
15. Document Summary Form ver: 1
16. Confidentiality Agreement ver: 1

Dr. Lianne Jeffs (REB# 14-168)
St. Michael's Hospital, 30 Bond Street, Toronto, ON M5B 1W8 Canada T 416.360.4000
Fully affiliated with the University of Toronto. stmichaelshospital.com

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During the course of this investigation, any significant deviations from the approved protocol and/or unanticipated developments or significant adverse events should immediately be brought to the attention of the REB.

Please note that if a Clinical Trial Agreement is required, it must be submitted to the Office of Research Administration for review and approval. Any additional institutional approvals **must be** coordinated and approved through the Office of Research Administration prior to initiation of this research. All drug dispensing must be coordinated through the Research Pharmacy at 416-864-5413.

The St. Michael's Hospital (SMH) Research Ethics Board (REB) operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans, the Ontario Personal Health Information Protection Act, 2004, and ICH Good Clinical Practice Consolidated Guideline E6, Health Canada Part C Division 5 of the Food and Drug Regulations, Part 4 of the Natural Health Product Regulations, and the Medical Devices regulations. Furthermore, all investigational drug trials at SMH are conducted by Qualified Investigators (as defined in the latter document).

With best wishes

☐ Dr. David Mazer
Chair, Research Ethics Board
DM/PS/BJ/Wkt



☐ Dr. Brenda McDowell
Vice Chair, Research Ethics Board

Appendix XIV – SMH Ethics Board Approval Renewal

Research Ethics Office
Telephone: (416) 864-6060 Ext. 2557
Facsimile: (416) 864-6043
E-mail: pateld@smh.toronto.on.ca

St. Michael's
Inspired Care.
Inspiring Science.

August 12, 2015

Dr. Lianne Jeffs,
Department of Nursing,
St Michael's Hospital

Dear Dr. Jeffs,

Re: REB# 14-168 - Beyond Transition: Workplace Integration of Internationally Educated Nurses: A Qualitative Case Study

REB APPROVAL:	Original Approval Date	August 01, 2014
	Annual/Interval Review Date	August 01, 2016

Thank you for your communications dated **14-July-2015** requesting an annual review and approval regarding the above named study.

This letter will serve as an extension of the St. Michael's Hospital (SMH) Research Ethics Board (REB) approval for the study for a period of 12 months effective from August 01, 2015 – August 01, 2016. Continuation beyond that date will require further review of REB approval.

The deliberation, review or approval of this submission did not include a Research Ethics Board member involved with this study.

During the course of this investigation, any significant deviations from the approved protocol and/or unanticipated developments or significant adverse events should immediately be brought to the attention of the REB.

The St. Michael's Hospital (SMH) Research Ethics Board (REB) operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans, the Ontario Personal Health Information Protection Act, 2004, and ICH Good Clinical Practice Consolidated Guideline E6, Health Canada Part C Division 5 of the Food and Drug Regulations, Part 4 of the Natural Health Product Regulations, and the Medical Devices regulations. Furthermore, all investigational drug trials at SMH are conducted by Qualified Investigators (as defined in the latter document).

Good luck with your investigations.

With best wishes

☐ Dr. David Mazer
Chair, Research Ethics Board
DMPB/BJM /djf

☒ 
Vice Chair, Research Ethics Board

☐ Dr. Brenda McDowell
Vice Chair, Research Ethics Board

Dr. Lianne Jeffs (REB# 14-168)

Page 1 of 1

St. Michael's Hospital, 30 Bond Street, Toronto, ON M5B 1W8 Canada T 416.360.4000
Fully affiliated with the University of Toronto. stmichaelshospital.com

Appendix XV - Consent Form for Interview

Researcher: Zubeida Ramji, Tel: [REDACTED]; Email: [REDACTED]

Study Title: Beyond Transition: Workplace Integration of Internationally Educated Nurses – A Qualitative Case Study

Purpose: Internationally educated nurses overcome many challenges in order to obtain registration and transition into the workplace. It is important to understand their experiences and aspirations beyond adapting to nursing in Ontario so that efforts to support their long term retention and integration are successful. This research's main aim is to understand what 'workplace integration' actually means and how it is achieved – both from the perspectives of internationally educated nurses, their managers and other colleagues they work with.

What you will be asked to do in the research: You would be asked to meet with the researcher for an in-person confidential interview lasting 1 to 1 ½ hours. The interview can be arranged for a mutually convenient time and in a quiet and comfortable space. At the beginning, after providing consent, you will be asked to complete a brief form providing demographic information about you. During the interview you will be asked questions about in three broad areas: What is meant by workplace integration of IENs? How does the workplace environment have to adjust to support workplace integration of IENs? What organizational factors facilitate or inhibit integration?

If you agree, the interview will be tape recorded so I can listen to them later rather than take notes while I am talking to you. Within a week of the interview, I will email you transcribed notes so you can check them for accuracy.

Once the data collection process has been completed, you will be invited to a group session where the key findings and preliminary analysis will be presented and discussed. You will have an opportunity to provide any further insights you have, including recommendations for how workplace integration for internationally educated nurses should be thought of and how it can be achieved.

Risks and Discomforts: We do not foresee any risks or discomforts from your participation in this experience. If any emotional or other problems arise for you, we will be sure to help you by providing information about support services.

Benefits of the Research and Benefits to You: The opportunity for joint learning and creation of new knowledge is expected to be mutually beneficial for the researcher and you, the participant.

Voluntary Participation: Your participation in this study is completely voluntary and you may choose to refuse to answer certain questions or stop participating at any time. Your decision not to volunteer or to withdraw will not influence the nature of your relationship with the researcher or your employer.

Confidentiality: All information you provide to the researcher will be kept confidential. All information that can identify you will be removed from the records. Any tapes, notes and meeting records will be marked with a code number and stored in a locked filing cabinet. Your name will be recorded only on the consent form we will ask you to sign but this will be kept in a separate place than the interview data. We are required to keep data collected for a minimum of 5 years, after which it will be confidentially destroyed. All information will only be accessible to the researcher or by the ethics board should they make a request. Any computer files relating to this study will be stored in computers with secret passwords.

When I report the results of this study, I may wish to use direct quotes from the interview or discussion group. I will not report details about you that would allow others to name you.

Compensation: In order to show my appreciation for your time and expertise, I will provide you with \$25 gift certificate as a thank you gesture.

Future use of data: I do not have plans for use of the information collected for this study other than what is explained in this form. The researcher may wish to use the information in future studies on related topics, or for teaching purposes. I will ask for ethics consent if I plan to use the data for future studies. Your name will be kept strictly private in any of these situations.

Contact for information about the study: Feel free to ask any questions, at any time, about any part of this study. You may ask questions to Zubeida Ramji, PhD Candidate, at: [REDACTED] or her doctoral thesis supervisor, Dr. Josephine Etowa [REDACTED] or the University of Ottawa Research Ethics Office at (613) 562-5367.

The plan for this study has been assessed for its adherence to ethical rules and approved by the University of Ottawa Research Ethic Board (REB) and St Michael Hospital REB.

I, (please print) _____ have read and understood the information on this research study. I consent to participate in: *Beyond Transition: Workplace Integration of Internationally Educated Nurses – A Qualitative Case Study* conducted by Zubeida Ramji under the supervision of Dr. Josephine Etowa. My signature below indicates my consent.

Participant Signature

Researcher Signature

Date

Appendix XVI- Consent Form for Focus Group

Researcher: Zubeida Ramji, Tel: [REDACTED]; Email: [REDACTED]

Study Title: Beyond Transition: Workplace Integration of Internationally Educated Nurses – A Qualitative Case Study Approach

Purpose: Internationally educated nurses overcome many challenges in order to obtain registration and transition into the workplace. It is important to understand their experiences and aspirations beyond adapting to nursing in Ontario so that efforts to support their long term retention and integration are successful. This research's main aim is to understand what 'workplace integration' actually means and how it is achieved – both from the perspectives of internationally educated nurses, their managers and other colleagues they work with.

What you will be asked to do in the research: The data collection process involving individual interviews and review of organizational documents has now been completed. You are being invited to a group session along with _____ (# and description of other participants). At the focus group session, key findings and preliminary analysis of the data will be presented first and then a facilitated discussion will follow. You will have an opportunity to provide any further insights you have, including recommendations for how workplace integration for internationally educated nurses should be thought of and how it can be achieved. If you and the other focus group participants agree, the interview will be tape recorded so I can listen to them later rather than take notes while I am facilitating the discussion. Within a week of the focus group, I will email you transcribed notes so you can check them for accuracy.

Risks and Discomforts: We do not foresee any risks or discomforts from your participation in this experience. If any emotional or other problems arise for you, we will be sure to help you by providing information about support services.

Benefits of the Research and Benefits to You: The opportunity for joint learning and creation of new knowledge is expected to be mutually beneficial for the researcher and you, the participant.

Voluntary Participation: Your participation in this study is completely voluntary and you may choose to refuse to answer certain questions or stop participating at any time. Your decision not to volunteer or to withdraw will not influence the nature of your relationship with the researcher or your employer.

Confidentiality: All information you provide to the researcher will be kept confidential. All information that can identify you will be removed from the records. Any tapes, notes and meeting records will be marked with a code number and stored in a locked filing cabinet. Your name will be recorded only on the consent form we will ask you to sign but this will be kept in a separate place than the interview data. We are required to keep data collected in secured office at the University of Ottawa for a minimum of 5 years, after

which it will be confidentially destroyed. All information will only be accessible to the researcher and her supervisor or by the ethics board should they make a request. Any computer files relating to this study will be stored in computers with secret passwords. During the focus groups, your opinions will be shared with the group, therefore, your identity and privacy cannot be guaranteed. If you have any sensitive issue that you prefer to share privately, the researcher will be available to discuss this with you alone. All focus group participants will be encouraged by the researcher to respect the privacy of individuals taking part in the group. When we report the results of this study, we may wish to use direct quotes from the interview or discussion group. We will not report details about you that would allow others to name you.

Future use of data: We do not have plans for use of the information collected for this study other than what is explained in this form. The researcher may wish to use the information in future studies on related topics, or for teaching purposes. We will ask for ethics consent if we plan to use the data for future studies. Your name will be kept strictly private in any of these situations.

Contact for information about the study: Feel free to ask any questions, at any time, about any part of this study. You may ask questions to Zubeida Ramji, PhD Candidate Tel [REDACTED] or my thesis supervisor, Dr. Josephine Etowa Tel [REDACTED] or the University of Ottawa Research Ethics Office at (613) 562-5367.

The plan for this study has been assessed for its adherence to ethical rules and approved by the University of Ottawa Research Ethics Board (REB) and St Michael's Hospital Research Ethics Board.

I, (please print) _____ have read and understood the information on this research study. I consent to participate in: *Beyond Transition: Workplace Integration of Internationally Educated Nurses – A Qualitative Case Study* conducted by Zubeida Ramji, under the supervision of Dr Josephine Etowa.

My signature below indicates my consent.

Participant Signature

Date

Researcher Signature

Date

Appendix XVII - Confidentiality Agreement

University of Ottawa, Faculty of Health Sciences, School of Nursing, PhD thesis

Beyond Transition: Workplace Integration of Internationally Educated Nurses

I, _____
(Specific job description, e.g., Transcriber has been hired for this research project.

I agree to –

1. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g., disks, tapes, transcripts) with anyone other than the *Researcher(s)*.
2. Keep all research information in any form or format (e.g., disks, tapes, transcripts) secure while it is in my possession.
3. Return all research information in any form or format (e.g., disks, tapes, transcripts) to the *Researcher/Zubeida Ramji* when I have completed the research tasks.
4. After consulting with the *Researcher/Zubeida Ramji*, erase or destroy all research information in any form or format regarding this research project that is not returnable to the *Researcher/Zubeida Ramji* (e.g., information stored on computer hard drive, memory cards, etc.).
5. All documentation contained with the shared drive shall remain confidential and will not be distributed, photocopied or reproduced without the permission of *Zubeida Ramji*.

(Print Name) (Signature) (Date)

Researcher(s)
(Print Name) _____

(Signature) _____

(Date) _____

Appendix XVIII - Receipt for Gift Card/Honorarium

HONORARIUM RECEIPT

Title of Study: *Beyond Transition: Workplace Integration of Internationally Educated Nurses*

Thank you for participating in the research project. As a sign of our appreciation for your time and support of this research study we offer you a small gift of \$25.00.

Please print your name and provide your signature in the places indicated and record your contact details.

Name:

Signature:

Signature of Researcher:

Contact Details:

Address:

.....
.....

Telephone:

Email:

Contact Names and Telephone Numbers: If you have concerns about your rights as a study participant, you may contact the Human Ethics Research Board at 613-562-5800 Ext 1787.

Please contact the following person if you have any other questions or concerns about the study:

Zubeida Ramji, PhD Candidate (Phone Number: [REDACTED]).