NON-ENGLISH SPEAKING NURSES MOVING TOWARDS CONTEXTUAL COMPETENCE IN VICTORIA

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Doctor of Philosophy

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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>AHCS</td>
<td>Australian Health Care System</td>
</tr>
<tr>
<td>AHW</td>
<td>Australia’s Health Workforce: Productivity Commission Research Report</td>
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<tr>
<td>ANCI</td>
<td>Australian Nursing Council Inc.</td>
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<tr>
<td>ANMC</td>
<td>Australian Nursing &amp; Midwifery Council</td>
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<tr>
<td>Atrial Fibrillation</td>
<td>Cardiac arrhythmia characterised by disorganized electrical activity</td>
</tr>
<tr>
<td>Auscultate</td>
<td>The act of listening for sounds produced within the body to evaluate the condition of the heart, blood vessels, lungs, pleura, intestines etc</td>
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<tr>
<td>CBAP</td>
<td>Competency Based Assessment Program</td>
</tr>
<tr>
<td>Craniotomy</td>
<td>The surgical removal of a portion of the cranium</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services</td>
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<tr>
<td>Digoxin</td>
<td>A drug prescribed in the treatment of cardiac failure</td>
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<tr>
<td>DEET</td>
<td>Department of Education and Training</td>
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<tr>
<td>Dialysis</td>
<td>A process that separates and removes from the blood the excess electrolytes, fluids, and toxins by use of a dialyser (Urden, Stacy and Lough, 2004)</td>
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<tr>
<td>EO</td>
<td>Equal Opportunity Act</td>
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<tr>
<td>Heparin</td>
<td>A drug that acts in the body as an anti-thrombin factor to prevent intravascular clotting</td>
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<tr>
<td>Iatrogenic diseases</td>
<td>Any disorder caused by treatment, diagnostic procedures or exposure to the environment of a health care facility</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<td>MDG</td>
<td>Millenium Development Goals</td>
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<td>MIMS</td>
<td>Drug reference guide</td>
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<td>NEDET</td>
<td>National Nursing and Nursing Education Taskforce (2004-2006)</td>
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<tr>
<td>NBV</td>
<td>Nurses Board of Victoria (Regulatory authority)</td>
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<td>NESB</td>
<td>Non-English Speaking Background</td>
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<td>NRA</td>
<td>Nurse Regulatory Authority</td>
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<tr>
<td>NRNE</td>
<td>National Review of Nursing Education (2002)</td>
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<tr>
<td>Nursing Handover</td>
<td>A report on the condition of patients in a given unit at the commencement of each shift, provided by the nurse on the outgoing shift.</td>
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<tr>
<td>OQN</td>
<td>Overseas-Qualified Nurses</td>
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<tr>
<td>PCA</td>
<td>Patient Controlled Analgesia</td>
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<tr>
<td>RCNA</td>
<td>Royal College of Nursing Australia</td>
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<tr>
<td>Resuscitation</td>
<td>The process of sustaining vital function in cases of cardiac and or respiratory arrest.</td>
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<tr>
<td>Volumetric pump</td>
<td>An electronic device used to regulate the flow of intravenous infusions</td>
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<td>VNRC</td>
<td>Victorian Nurse Recruitment Committee</td>
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SUMMARY

The purpose of this study was to obtain an in-depth understanding of the perceptions of overseas-qualified nurses from non-English speaking backgrounds (NESB) in relation to their educational and socialisation experience whilst enrolled in a Competency Based Assessment Program (CBAP).

The study was conducted using a modified grounded theory approach. There were a total of seventeen participants; fourteen NESB nurses, and three teachers who were directly involved with their education in the CBAP. The NESB nurses who participated fell into three main groups in terms of their previous professional experience. These were:

- Specialist
- Experienced generalist
- Inexperienced generalist

However, the level of skill and experience that the nurses brought to the educational and practice encounter made no difference to their experience of prejudice and lack of support, particularly in the clinical environment. The education and clinical experience they received challenged feelings of competency as much as they expanded feelings of competency. The NESB nurses’ experiences of diversity also challenged their feelings of competence. In addition, the level of previous experience did not reduce the concern expressed by NESB nurses regarding the possibility of finding appropriate employment following registration. The implications of this for the profession and the health care system are that even the most experienced specialist and generalist nurses are not having their level of skill appropriately recognised and utilised in a timely way despite the current shortage of generalist and specialist nurses in Victoria.
The outcome of the study led to the development of a model that has the potential to lead to a culture change in the clinical environment with a view to improving educational opportunities and experiences for NESB nurses who are enrolled in CBAP. In addition, the model has the potential to be useful in terms of providing local nurses with an opportunity to express their own thoughts and ideas in relation to the education of NESB nurses in the clinical environment. The model is based upon the theoretical perspectives of “productive diversity” and “clinical governance and organisational learning”.
STATEMENT OF AUTHORSHIP

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any other degree or diploma.

No other person’s work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

All research procedures reported in the thesis were approved by the Human Research and Ethics Committee of LaTrobe University, Melbourne (See Appendix 4), and participating universities and hospitals on the understanding the such organizations should remain anonymous.

Joan Deegan
Date April 2007
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I wish to express my sincere thanks to all who contributed to the success of this thesis. In particular, I wish to thank the overseas-qualified nurses who participated in this research and who were so generous with their time and their ideas. Without them this work would not have been possible.

To my supervisor Dr Keith Simkin who has provided invaluable advice and support throughout this project. Keith’s approach to mentoring and teaching has provided me with an opportunity to develop my research and writing skills, and more importantly to emerge from this experience with a real sense of having enhanced my knowledge and skills as a researcher and as an educator.

To Dr Catherine Krejany for invaluable assistance with the editing and formatting of this thesis.

Finally, my most sincere thanks to my two sons Garret Douglas and Liam Elliot Deegan and to my partner John Esson for the unconditional love and support that I received throughout the research and writing process.
CHAPTER 1

INTRODUCTION AND BACKGROUND
1.1 INTRODUCTION

1.1.1 Purpose of the Study

The purpose of this study was to obtain an in-depth understanding of the perceptions of overseas-qualified nurses from non-English speaking backgrounds (NESB) in relation to their educational and socialisation experience whilst enrolled in a Competency Based Assessment Program (CBAP). The rationale for conducting the study was developed from recognition of the fact that overseas-qualified nurses make a significant contribution to the delivery of nursing services in Australia, both in terms of the increasing numbers who practice in Australia, and the experience and expertise these nurses bring to the profession and to the nursing workforce. The purpose of this chapter is to provide the necessary background information to understand the context of education for overseas qualified nurses in order to be eligible for registration in the state of Victoria.

One aspect of this background is the emergence of competency-based assessment and its consequences for the evaluation of NESB nurses whose original qualifications were assessed by different standards. The other part of this background discusses the increasing mobility of nurses globally and their contribution to alleviating local nursing shortages in many of the developed nations. The issues raised by competency based assessment systems and the need to adapt to the cultural and linguistic diversity of the Australian health care system support the rationale for this research study.

The study was conducted using a grounded theory approach. Data were collected using in-depth interviews, observation, and personal journal entries. There were a total of seventeen participants: fourteen NESB nurses, and three teachers who were directly involved with their education in the CBAP. A modified grounded theory approach to data collection and analysis provided rich
contextual data that enabled the development of a model that outlines the factors that expedite and inhibit both theoretical and clinical learning in the educational environment.

It is argued in this thesis that the model has the potential to be beneficial in terms of enabling nurse educators, nurse unit managers (NUM), clinical nurses and other significant stakeholders to understand the challenges experienced by NESB nurses in the tertiary education system and the health workforce in Australia. It is also suggested that this understanding may provide a way for educators, employers, and clinical nurses to improve professional education and facilitate the adaptation of the NESB nurses to the Australian context.

1.1.2 Competency Based Assessment Programs (CBAP) for Overseas Qualified Nurses

At present CBAP for overseas-qualified nurses are generally conducted through Schools of Nursing within the tertiary education sector. There are, however, some hospital based programs available which are generally referred to as “supervised practice”. These programs vary in structure and content compared with the CBAP conducted within the tertiary sector. This study focused on the experiences of NESB nurses who were enrolled in CBAP at two universities in the state of Victoria. Hospital based supervised practice programs were not explored.

The structure and duration of the CBAP that are conducted within the tertiary education system vary between universities. However, the main aim of the programs are to assist nurses from overseas who have had their nursing qualifications assessed by the Australian Nursing and Midwifery Council (ANMC) or the relevant state registering authority and who, as a result, are required to undertake a CBAP prior to becoming eligible for registration as a nurse in Australia (ANMC, 2004). The programs consist of a theoretical and a
clinical component and are intended to provide an opportunity for migrant nurses to demonstrate the ANMC National Competency Standards required by nurses for entry to practice in Australia (ANMC, 2004; Appendix 1.) The curricula in all programs, regardless of local variations in structure and duration, is informed by the ANMC Competency Standards for Registered Nurses and Midwives. The main aim of the CBAP then is to facilitate the acquisition of contextual competence (ANMC 2004).

**Philosophy of Competency Based Assessment Programs (CBAP)**

A copy of the course philosophy was obtained from one of the participating universities and the key points from that document will be outlined herein. The course philosophy for the second university was not available at the time. The course philosophy is based upon principles of adult learning and cross-cultural understandings with the primary importance being the delivery of nursing care in a variety of health care settings serving culturally diverse populations. It is stated that the philosophical position will be underpinned by a learning experience that is designed within a framework of collaboration, inclusiveness, and a positive regard for the value of diversity. It is also noted that previous knowledge and skill will be acknowledged and new knowledge will be fostered. This is said to occur in an environment that encourages self-direction and reflective practice leading to the development of critical and analytical skills and engagement with the individual’s creative potential.  

1.1.3 Competency

In the tertiary education system in Australia, competence is used in relation to skill development. This is underpinned by the ANMC Standards commonly referred to as the ANCI competencies (White, 2004). These are a set of minimum

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1 The course philosophy has been taken from the documentation of one participating university and is acknowledged.
Chapter 1

Introduction and Background

Competencies accepted by all regulatory authorities in Australia. There are fourteen competencies incorporated in four domains: 1) Professional and Ethical Practice, which includes practising within the law; 2) Reflection, which includes, professional development and valuing and utilising research findings; 3) Problem Solving, which includes comprehensive patient assessment and the provision and evaluation of care; and 4) Enabling, which includes safety, communication, collaboration and management (White, 2001; Appendix 1). Competence in nursing therefore depends upon knowledge, skills, clinical judgement and language proficiency (American Association of Colleges of Nursing, 2006; Gonszi et al., 1990).

Benner (1984), one of the most influential writers on nursing competence, has defined competency as the ability to perform tasks with the desirable outcomes under varied circumstances of the real world. Other researchers (Benner, Sutphen, Day, 2006; Benner, Tanner and Chesla, 1996; Campbell and Mackay, 2001) also note that the practice setting will impact on competence. The challenge for NESB nurses is that the real world that Benner refers to is likely to differ in significant ways from the real professional world previously known to them. This is likely to be the case both in terms of the specialities involved in the clinical practice environment, and the cultural, organisational and political systems that operate within that clinical environment. This difference can, for the NESB nurse undertaking a CBAP, lead to considerable loss of autonomy, professional status and contextual competence.

In seeking to explain this phenomenon there is utility in the work of Benner (1984:38). Benner refers to air force studies conducted by Dreyfus and Dreyfus (1977) in which it was found that if experts were required to return to the rules and guidelines that they used as beginners their performance actually deteriorated. Achieving contextual competence then, if considered in this way,
can be a challenging and anxiety-provoking experience for NESB nurses. In addition, it is claimed that the process of contextualisation is a pedagogical task in itself requiring the individual to attend to the socially situated aspects of knowledge and to participate constructively in the encounter of context (Benner et al., 2006). The author’s recognition of this process occurring with students of nursing during her years as a nurse educator was one of the powerful incentives to investigate whether or not this process was occurring on a regular basis among overseas trained nurses whilst enrolled in CBAP. Although a comprehensive theoretical framework was not developed ahead of the empirical study, my views on the emergent themes were influenced to an extent by the views of the authors mentioned above. These perspectives then underlie the approach taken in this thesis. The NESB nurses interviewed for this research expressed two major concerns: one was about their difficulties making sense of, and gaining competence in, the local setting; and the other was in relation to their prospects of securing employment in the area of professional practice in which they felt they held the greatest amount of educational preparation and professional expertise.

1.1.4 Location of the Study Population

There are a number of CBAP conducted within Faculties and Schools of Nursing throughout Australia. This study focused on the perceptions of overseas-qualified nurses enrolled in CBAP programs conducted at two universities based in the state of Victoria. These programs are approved by the Nurses Board of Victoria (NBV) in accordance with the Nurses Registration Act (1993).

It is suggested by Wickett and McCutcheon (2002) that previous experience will have a significant impact on nurses’ knowledge base and on how they view their role in the delivery of health care. Wickett and McCutcheon explain this phenomenon in terms of the fact that nurse education and practice reflect the needs of the community served. The variations in practice settings, educational
preparation, and experience in practice merely reflect the diversity of practice required and the scope of practice possible. Therefore, skill mix will vary among countries as indeed they do amongst organisations (Buchan and Calman, 2005). These points are important here because participants in this study came from a diverse range of cultural backgrounds, professional practice and educational backgrounds, as well as a range of linguistic variations. The countries of origin of the participants were India, China, Philippines, Czech Republic and El Salvador. With these diverse backgrounds, they faced considerable challenges to their personal views of the profession, the professional adaptation process, and their own professional identity during their period of enrolment in the CBAP.

It is noted by Hawthorn (2001) that the adjustment process for NESB nurses has not received sufficient policy attention in the past despite their potentially profound impact on workforce cohesion and supply. Similarly, it is suggested by (Rutherford-Dijhuizen, 1995) that careful analysis of the needs of nurse immigrants and the development of methodologies to meet those needs are important to ensure the retention and job satisfaction of foreign nurses.

It is also possible that such an understanding of educational needs and adjustment issues from the overseas-qualified nurses perspective could provide a significant and possibly an original contribution to knowledge in this field in the light of the fact that, at the time of writing this thesis, no studies have been carried out with NESB nurses who are enrolled in a CBAP in the state of Victoria.

1.2 AIMS OF THE STUDY

The study aims are:

1. To identify key issues that impact on the professional education, socialisation and adaptation of nurses from non-English speaking backgrounds.
Chapter 1

Introduction and Background

2. To develop a greater understanding of these issues through in-depth interviews, observation, and personal diary entries maintained by the participants.

3. To suggest educational strategies with the specific aim of improving the quality of professional bridging programs and the associated clinical education component.

4. To contribute to the discourse on productive diversity and the management of diversity in nurse education and practice through the development of theoretical perspectives that will be useful to curriculum planners and nurse education practitioners as well as nurse managers, clinical nurses, and policy makers.

1.3 Rationale for the Study

1.3.1 National Level

At present in Australia little is known about the experiences and contributions of foreign-born nurses from non-English speaking backgrounds (Omeri and Atkins, 2003). If considered in the light of current trends in the global movement of nurses and the current shortage of qualified nurses it makes sense to examine the issue from both a national and international perspective.

Historically, nursing has provided ease of mobility for nurses (Armstrong, 2003) from many countries such as North America, Canada, the United Kingdom and Ireland (Kilstoff and Baker, 2006). The movement of nurses then has been predominantly from English-speaking industrialised nations. More recently however, that trend has changed giving way to a global trend in which nurses from a diverse range of cultural and linguistic backgrounds are arriving in Australia. It is claimed by Kilstoff and Baker (2006:8) that, anecdotally at least, the international reputation of Australian health and educational institutions make such a move attractive. If this is the case it seems that, from the results of this
study, at least some NESB nurses find that the reality of the situation does not match the anecdotal evidence, or at least does not entirely match their expectations.

A current investigation of the perceptions of NESB nurses could be of significant interest to nursing faculties in Australia as many have sought to increase their enrolments of international students of nursing in recent years (Kilstoff and Baker, 2006). According to Kilstoff and Baker (2006), this situation has arisen from two seemingly unrelated factors. Firstly, pressure for Australian universities to be more responsible and accountable has resulted in institutions seeking income opportunities from offshore. Secondly, it is often hoped that students will remain and work in Australia following graduation, thereby helping to relieve the shortage of nurses in the local context.

The study by Kilstoff and Baker (2006) referred to postgraduate and undergraduate students of nursing; that is, those who are enrolled in undergraduate, masters, and doctoral studies, as distinct from nurses who are enrolled in the much shorter CBAP. Nonetheless, the rationale for the provision of CBAP in the tertiary education sector bears many parallels to the rationale for attracting international postgraduate and undergraduate students of nursing from NESB backgrounds. This is because both populations represent full-fee paying international students who increase income opportunities for participating universities. There are also other overlapping issues between NESB nurses enrolled in CBAP and NESB nurses enrolled in undergraduate and postgraduate studies. These relate mainly to linguistic and cultural issues which impact on the learning experience both on campus and, more particularly, in the clinical learning environment. It is important to note, however, that considerable differences do exist between nurses who are enrolled in postgraduate studies and those who are enrolled in CBAP. One of the most significant differences relates to
the relatively short duration of the CBAP and the need to demonstrate competence in that time in order to be eligible for registration in the state of Victoria.

A more important consideration for the health care sector, though, is the fact that NESB nurses who enrol in CBAP do so with the sole intention of becoming registered for practice in Australia and are therefore a potentially valuable resource in the light of the current shortage of qualified nurses. Non-English speaking nurses who are enrolled in postgraduate programs, on the other hand, have an interest in gaining a postgraduate qualification in Australia but many return to their country of origin to apply that knowledge and skill. However, they may apply for registration in Australia following the relevant qualification assessment process.

Over the past two decades, Australia has become increasingly reliant on migrant nurses (Hawthorn, 2001) and with a projected shortfall of 40,000 nurses by 2010 (Department of Education Science and Training [DEST], 2002) the trend is unlikely to change significantly in the near future. Since 1996, sustained migration of overseas-qualified nurses has resulted in a dramatic diversification of the nursing profession in Australia (Hawthorn, 2001). This trend is reflected in the increase in the numbers of overseas-qualified nurses who have registered with the Nurses Board of Victoria (NBV). In 2003 there was an increase of 8.5% in the number of nurses professionally educated overseas who registered in the state of Victoria and 42% of those registrants were educated in NESB countries (NBV, 2003). In 2005, whilst there was a decrease of 13.4% in overseas registrations, there was an increase of 81% in registrants from India and an increase of 44% in registrants from China. Meanwhile, there was a decrease of 8% and 17% recorded among registrants from the United Kingdom and New Zealand respectively (NBV, 2005). Nonetheless, it seems that attempts to recruit
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English-speaking nurses persisted in the Australian mentality until recent times as this comment from a recruitment agency executive would seem to suggest: “We look for people who can assimilate well into our health care system, and nurses from the UK can generally do that” (De Haard, 2003). However, it appears that the availability of nurses from that source is in decline.

A number of factors have been said to account for the steady increase in the numbers of overseas qualified nurses practising in Australia: the international shortage of trained nurses (Cowin and Jacobsson, 2003; Hawthorn, 2001; Kingma, 2001; Kline, 2003; RCNA 2002), the associated aggressive recruitment by local agencies (Cowin and Jacobsson, 2003; Kline, 2003; Omeri and Atkins, 2002), and recruitment and retention issues (Lumby, 2002; Nay and Pearson, 2001; Sigma Theta Tau International, 2001). The recruitment and retention issues may be associated with multiple factors such as the conditions of nurses’ work (Brownson and Harriman, 2000; Keleher and McInerney, 1998); failure on the part of planners to recognise the increased intensity of nurses’ work (Armstrong, 2003); increased mobility among professionals (Kingma, 2006); the rising participation of women in skilled migration (Bach, 2006; Hawthorn, 2001) with prospects of educational and employment opportunities (Omeri and Atkins, 2003); the traditional association of nursing with femininity and women’s work (Buchan and Calman, 2005) which is said to make the profession unattractive to men (Pearson, 2004); and finally a decrease in registrations of nurses from the United Kingdom and New Zealand (NBV 2005).

Hawthorn (2001) claims that nurses from NESB backgrounds experience a particularly protracted and difficult adjustment period in Australia. Hawthorn also remarked that in the light of the current trends the lack of research interest in this phenomenon is startling. This highlights the timeliness of this study in terms of providing much needed data regarding the needs and experiences of NESB
nurse registrants and has the potential to assist with the future planning and delivery of bridging programs and the transition to professional practice in the Australian context.

1.3.2 International Level

At the international level, mobility and a dramatic rise in the migration of nurses is said to be a defining characteristic of the 21\textsuperscript{st} century (The American Association of Colleges of Nursing, 2006). It is claimed by Buchan and Calman, (2005:1) that the scarcity of nurses is one of the biggest obstacles to achieving the Millennium Development Goals (MDG) for improving the health and wellbeing of the global population. These authors point out that international organisations, such as the World Health Organization, the World Bank, the Organisation for Economic Cooperation and Development (OECD), and the Rockefeller Joint Learning Foundation Initiative, are focusing on the growing challenge of ensuring that there is sufficient workforce capacity to enable health systems to function effectively.

According to Buchan and Calman (2005) the most critical component of the health workforce is nurses given that they are the front line staff in most health care systems and that their contribution is essential in terms of meeting the MDG of delivering safe and effective care. It is recognised at the local level that they play an essential role in promoting and achieving the health outcomes of the Australian community (Australian Institute of Health and Welfare [AIHW], (2006). In this context it is argued that professional regulation and educational standards become a focus of attention (American Association of Colleges of Nursing [AACN] 2006). It is argued in this thesis that an exploration of the educational experiences of NESB nurses who are enrolled in CBAP has the potential to enable stakeholders to focus on educational standards and processes for that group.
It is noted in a report from Sigma Theta Tau International (2001) that there is a shortage of nurses worldwide, with Canada, Australia and Western Europe all reporting significant nursing shortages. Countries such as Africa and South America have also reported severe shortages (Buchan and Calman, 2005). It is vital that the shortage of nurses in Australia be viewed in the international context as the shortage elsewhere provides attractive opportunities for Australian educated nurses (Hawthorn, 2001; Lees, 2001 [Hansard]; Royal College of Nursing Australia [RCNA], 2002), thereby further reducing the pool of registered nurses at the local level. According to Bryant (2005), nursing shortages give rise to the potential for unsafe practice because of poor nurse to patient ratios. Bryant (2005) suggests that one method of alleviating a shortage is to allow nurses from outside the country into practice. It is argued in this thesis that if nurses from NESB backgrounds are to function at an optimal level of professional competence in the Australian context then the relevant stakeholders at the policy and practice levels need to be conversant with the educational and professional needs of that group. It is suggested by Janiszewski-Goodin (2003) that today’s shortage of nurses will not be addressed by returning to the solutions of the past. Instead, strategies to reduce the impact of the shortage will need to be more creative and focused on the long term.

It is suggested in this thesis that such strategies must focus generally on current trends in the movement of nurses worldwide and in particular on the increasing numbers of registrants from NESB backgrounds in Australia (NBV, 2005). Strategies must also focus on the concerns expressed by NESB nurses in relation to their educational preparation for practice in the Australian context. The relevance of this study is in developing a model that has potential value at the local level in terms of addressing the shortage by capitalising on the generalist and specialist skills of NESB nurses. It suggests that gaining an understanding of NESB nurses’ perceptions of their educational experiences within the tertiary
based education system would be useful to stakeholders such as nurse academics, nurse unit managers (NUM) and senior management personnel. This knowledge would, in turn, guide the implementation of the necessary organisational and educational support to enable NESB nurses to contextualise their existing skills and to develop additional contextual skills.

This model is relevant for NESB nurses because they frequently experience difficulties with language; communication styles (Josipovic, 2000; National Review of Nursing Education [NRNE], 2002); and unfamiliar nursing practice, work environments and cultural differences (Kilstof and Baker, 2006; Yun-Hee and Chenoweth, 2007). The experiences of NESB nurses who are enrolled in CBAP is an area of nurse education about which little is formally known, as a statement issued by the New South Wales College of Nursing would seem to suggest:

The College offers four courses per year for pre registration assessment of overseas-qualified nurses funded by the State Health Department. Applications are received from more than thirty countries (more than 140 nurses) per year. According to the National Review of Nursing Education on Multicultural Education [NRNE] (2002), the College is aware that the needs of overseas-qualified nurses seeking employment in Australia may be very different to those of fee paying overseas students.

However, no suggestion was put forward at that time in relation to the nature of those differences, nor was there any indication that research is being undertaken at this point in time to explicate the issue.
It is noted by Buchan and Calman (2005) that an important aspect of ensuring workforce planning in health care is the recruitment and retention of nurses. In Victoria, the Victorian Nurse Recruitment Committee (VNRC) was convened in 2000 by the Minister for Health. The Committee membership was chosen by the Minister and was composed of a broad cross section of the nursing workforce drawn from both metropolitan and rural clinical nurses, the tertiary sector, industrial and professional bodies, and hospital management. The committee focused on issues relating to the attraction and recruitment of nurses, the exodus of nurses from the workforce, and the retention of experienced nurses in the public sector (Nurse Recruitment and Retention Committee Government Response, 2001). However, when the eighty-six recommendations directed to the Victorian Government, Health Service Management, the tertiary education sector, and the Commonwealth Government were handed down in 2002, there was not a single reference to the recruitment and education of NESB nurses. At the national level, the Royal College of Nursing Australia (RCNA), in its recommendations to the Senate Inquiry into the shortage of nurses identified a range of factors believed to be responsible for the shortage, and submitted twelve recommendations on ways in which that shortage could be addressed (NRNE 2002). However, none of the recommendations reflected a commitment to exploring the educational and professional socialisation needs of NESB nurses, either at tertiary education level, or in relation to support structures within the clinical environment to identify skills and to enable overseas-qualified nurses to adapt to the professional environment. This is despite Hawthorn’s evidence that since 1996 sustained migration of overseas-qualified nurses has resulted in a diversification of the nursing profession in Australia with a dramatic increase in the numbers of nurses from non-English speaking background countries (Hawthorn, 2001).
The shortage of qualified nurses in Victoria means that there is an increasing demand for the skills of overseas-qualified nurses from non-English speaking backgrounds to meet the growing need for qualified nurses in the health care workforce. It is recognised in the NRNE (2002) that the overseas-qualified nurses are an untapped resource in nursing in Australia, particularly in relation to the recruitment and regulation of that group. Nevertheless, the international movement of nurses continues to be a reality at a global level (Bach, 2006; Buchan and Calman, 2005; Buchan, Parkin, and Sochalski, 2003; Cowin and Jacobsson, 2003; Hawthorn, 2001; Kingma, 2001; Kingma, 2006; Kilstoff and Baker, 2006; Kline, 2003; NBV, 2005; Yun-Hee and Chenoweth, 2007) and it is noted by Hawthorn (2001) that failure to acknowledge this reality at policy level could have a profound impact on workforce cohesion and supply in the future.

The empirical evidence derived from this study has the potential to provide a significant basis to enable stakeholders to address the self-proclaimed educational needs of NESB nurses who are enrolled in CBAP. Whilst it is recognised here that qualitative results and an associated theoretical position do not provide any absolute truth about a given issue, nonetheless, it can provide a view of reality as experienced by people who know about the phenomenon (Barnes, 1996). This knowledge can subsequently provide a focus for larger scale empirical studies that provide data more amenable for generalisations useful in policy making and practice in training programs and clinical settings.

1.4 SUMMARY

The main argument presented in this chapter centres on the proposition that conducting a grounded theory study involving overseas-qualified nurses has the potential to be useful in identifying issues, clarifying perceptions of issues, and identifying potential solutions that are not being canvassed in the current literature. The study has the potential to contribute to measures to improve skill
identification, recognition, and utilisation in the local context. Such a move has the potential to partially address the current shortage of registered nurses through improved educational processes and avoidance of skill wastage. This is important on the basis that there are indications that there is a continuous increase in the numbers of NESB nurses who have registered in the state of Victoria in recent years and a decrease in the numbers of registrants from traditional supply countries such as the United Kingdom and New Zealand (NBV, 2005). The next chapter will address the approach adapted to the review and the utilisation of the literature as an adjunct to the grounded theory approach to this study.
CHAPTER 2

LITERATURE REVIEW
2.1 Introduction

This chapter has two purposes. First, it sets out the position taken in this thesis in relation to the use of literature in the grounded theory approach. Second, it provides an overview of the literature that is relevant in terms of locating the study in the current context of the global shortage of nurses, the global movement of nurses and some of the difficulties experienced by NESB nurses in the Australian context.

The literature review for this thesis was conducted in two phases. The first phase was conducted prior to the commencement of the empirical research. That phase of the literature review served to locate the study in terms of relevance and timeliness in the current context of the shortage of nurses nationally and internationally and the global movement of nurses associated with that phenomenon. It also helped me to gain some initial insights (Glaser and Strauss, 1967: 45) in relation to issues associated with current nurse education and practice, and issues associated with the experiences of NESB nurses prior to (Hawthorn, 2001) and following registration in Australia (Jackson, 1995). This strengthened my initial focus on diversity in relation to the education of NESB nurses in the academic and clinical environments. By initial focus it is meant that the author’s initial view, based on my own professional experience, is that the educational needs of NESB nurses who are enrolled in CBAP differ from and could be more complex than those of the undergraduate student population. It also served to sharpen my focus on the impact of contextual influences on the ability of nurses to perform at an optimal level in a clinical environment (Benner, 1984). Although a comprehensive theoretical framework was not developed prior to the commencement of the empirical study; nonetheless, my views on the emergent themes were influenced by the views of Benner (1984) and the findings of Jackson (1995).
The second phase was conducted as soon as the emergent categories seemed sufficiently grounded in a core variable (Glaser, 1992). The core variable was “Moving Toward Contextual Competence in Victoria”. This was so named because it was clear from the data that the focus of the participants was to work towards, and gain the requisite level of competence for, practice as Division One nurses in the state of Victoria. The review of the literature in the substantive area made it possible to relate the existing literature to this work to, in the words of Glaser (1992), “imbue” the work with relevant concepts from the related literature that were discovered through that review. This provided an opportunity to sharpen the focus of emergent issues and enhance the generative nature of the work (Glaser, 1992). It helped to place the emergent themes within the broader context of nurse education and practice as well as delineating the issues that relate specifically to the experiences of NESB nurses.

2.1.1 Theoretical Views on Grounded Theory

In discussing the grounded theory method, Glaser (1992:32) stresses the importance of not reviewing any of the literature in the substantive area prior to commencing the grounded theory study. The rationale for this approach is, according to Glaser (1992), that it is difficult enough to generate one’s own concepts without the added burden of contending with distractions provided by the related literature. In other words, a grounded theory should overcome the difficulties associated with identifying what is problematic from the respondents’ point of view by relying on in vivo codes and concerns that are expressed repeatedly by respondents (Strauss, 1987).

Nonetheless, others (Descombe, 1998; and Strauss and Corbin, 1990) suggest that the literature can be used to guide the research procedure in a variety of ways such as establishing the significance of the research in the light of current knowledge derived from research in the area; in developing questions to guide
the initial data collection and observations; and to enhance theoretical sensitivity.

The initial framework to assist with data collection in this study was not based on the literature review alone but also on my professional background knowledge on the topic (Cutcliffe, 2000) and a limited number of interviews with five NESB nurses who had graduated from a CBAP shortly before the empirical study was commenced. Strauss and Corbin (1990) also stress the essential nature of published literature at all stages of the research. Points of difference exist then between the views of Glaser (1992) and those of Strauss and Corbin (1990) on this issue. However, in Glaser’s view the avoidance of using literature in the substantive area only applies at the beginning of the research process. So as soon as the theory seems sufficiently grounded in a core variable, and there is evidence of emerging integration of categories and properties, then a review of the literature in the substantive area is appropriate in order to relate the literature to the researchers own work.

The approach to the literature review in this thesis entailed some overlap on the points of view put forward by Glaser and Strauss (Glaser, 1992; Glaser and Strauss, 1967; Strauss and Corbin, 1990). The initial review of the literature was conducted to locate the topic in the existing research and to gain some initial insights into the phenomenon through viewing related studies. In addition, it was used to gage the relevance and timeliness of the study in relation to nurse education and practice and current trends in the international movement of nurses. It also helped with the development a partial framework consisting of what Glaser and Strauss (1967:45) referred to as “local concepts”.

Following the initial review, further use of the literature was placed on hold until the core category had emerged (Glaser, 1992). Glaser (1992:31) explains that this view is brought about by concern not to contaminate, be constrained by, inhibit, or stifle the researcher’s effort to generate categories, their properties and
theoretical codes from the data. However, Glaser and Strauss (1967) suggest that the researcher needs to be sufficiently sensitive to enable them to conceptualise and formulate a theory as it emerges from the data. It was equally important, however, to avoid further use of literature throughout the data collection and in the early stages of the analysis. There was a practical as well as a theoretical reason for not continuing to review the literature during the data collection and analysis stage. This related to the time critical nature of the opportunity to collect data. The time frame was relatively short, approximately three months, with an even shorter time frame to observe participants during the clinical practice component of the program. This left little time to devote to engaging with the literature.

Glaser (1992:32) emphasises the value of theoretical sensitivity during the grounded theory process particularly when the theory is sufficiently grounded in a core variable and in an emerging integration of categories. In fact Glaser (1992) suggests that at this point the researcher can show similarities in patterns and concepts and can imbue the work, with the data that has just been analysed, with concepts from the literature.

It will be seen in the data chapters in this thesis that the literature in relation to several areas of the nurse workforce, for example the nurse education landscape and issues associated with cultural and linguistic diversity, is integrated in this way. In the view of Glaser (1992) this approach enables the researcher to sharpen the ideas generated from the data with ideas from the literature. Glaser (1992) stresses that the exercise remains generative and is not intended to verify extant ideas and theories, although it can generate similarities and differences between the current study and previous studies as is the case with this thesis.
Apart from Glaser (1992) and Strauss and Corbin (1990), other proponents of grounded theory have joined the debate regarding how best to approach the use of literature in grounded theory studies. Cutcliffe (2000:1480) shares the view of Glaser (1992) that apart from a few basic concepts, when using grounded theory, the researcher should avoid conducting a literature review prior to commencing data collection and analysis. In addition, Stern (1980) puts forward the notion that a second search becomes necessary as a process that helps to explain actions in the social scene as they begin to emerge from the data. As indicated previously in this study, the literature was most useful in that context to help to explain emergent issues and also to delineate similarities and differences (Glaser, 1992).

The literature review in this study, therefore, was conducted in one minor phase and a major phase; that is, prior to commencing the study in order to identify studies in the same and or related areas, and for the purpose of locating the study in the current research and social context respectively (Glaser, 1992; Stern, 1980). A more selective literature sampling was conducted following the initial data analysis in order to compare existing literature in related areas with the major themes that emerged from the data. These themes have been labelled as: **Teaching and Learning, Adaptation, and Experiencing Diversity.** This phase of searching, reading, analysing and comparing literature with the participants’ perspectives continued throughout the remainder of the study, including the writing up phase.

### 2.2 The Initial Review

The initial review of published literature relating to the experiences of non-English speaking nurses failed to identify research of this kind in relation to the perceptions of NESB nurses regarding their educational experiences whilst enrolled in a CBAP in Victoria. The lack of existing studies regarding the perceptions of NESB nurses of their educational experiences whilst enrolled in a
CBAP supported the decision to undertake the study and to utilise the grounded theory approach to explore the phenomenon (Cutcliffe, 2000; Stern, 1980).

The phenomenon of the integration of overseas-qualified nurses into the Australian health care workforce has been the subject of inquiry by a number of stakeholders both in the realms of government and academia since the 1980s (Burner et al., 1990; DHS, 2001; Gonda et al. 1995 Hawthorn, 2001; Hurst, 1989; Jackson, 1995; Josipovic, 2000; McCloskey and Aquino, 1988; NRNE, 2002; O’Loughlin and Dunnell, 1990; Omeri, Malcolm, Ahern and Wellington, 2003; Omeri and Atkins, 2003; Pitman and Rodgers, 1990a; Teschendorf, 1995; Thiederman, 1989; Williams, 1992). These studies revealed that NESB nurses experience a significant degree of discomfort in gaining access to and adapting to the practice of nursing in Australia.

Previous studies highlighted related concerns in areas such as:

1. Meeting the challenge of cultural diversity in the academic setting
2. The lived experiences of immigrant nurses in New South Wales
3. Language skills assessment and recognition of overseas qualifications
4. Culturally sensitive curriculum
5. Studies of nurses from non English-speaking backgrounds in the Australian workforce
6. Evaluation of Bridging Programs for Migrant Nurses
7. Broader political context: national level
8. The Global Shortage of Registered Nurses: International Level
9. Nurse Regulation

Some published works on these issues were opinion based (Gonda et al., 1995; Hurst, 1989) while others were research based (Hawthorn, 2001; Jackson, 1995; Josipovic, 2000; Omeri and Atkins, 2003; Omeri et al., 2003; Pitman and Rodgers, 1990a) . The following sections of this chapter will provide a brief description of
those studies and are intended to place this study in context and to illustrate the timeliness and significance of this study.

2.2.1 Related Studies Described

*Meeting the Challenges of Cultural Diversity in the Academic Setting*

Omeri et al. (2003) conducted a systematic review of research studies to identify transcultural tertiary education experiences and the approaches of students and academics. The aim of the study was to discover educational strategies that could enhance teaching and learning situations in diverse teacher and student encounters. The focus, however, was international students enrolled in mainstream undergraduate programs as distinct from the subject of this inquiry, that is, the perceptions on NESB nurses of their educational experiences whilst enrolled in CBAP. It is relevant to this study to the extent that the participants faced many similar challenges to those experienced by international students generally.

*Lived Experiences of Immigrant Nurses in New South Wales*

In seeking to understand the experiences of immigrant nurses, Omeri and Atkins (2003) utilised a hermeneutical approach based on Heideggerian phenomenology. The aim of the study was to develop a greater understanding of what it means to be an immigrant nurse through exploring and describing the experience as lived by immigrant nurses entering a new country, language and culture to engage in professional practice. In brief, the findings of this study revealed three main categories: (1) Professional Negation, which was associated with such issues as difficulty finding employment following registration; (2) Otherness, which was associated with feelings of separateness and feelings of isolation and loneliness; and (3) Silencing, which was related to language and communication difficulties in the clinical environment. Participants were selected on specific criteria, they had to have: been born outside Australia; been from a
non-English speaking background; immigrated to Australia; studied nursing in their country of origin; and registered and worked in their country of origin. The study conducted by Omeri et al. differed in selection criteria, aim and methodology from this study, but both populations were immigrant nurses.

**Language Skills Assessment & Recognition of Overseas Qualifications**

Hawthorn (2001) conducted a detailed study of four major databases and analysed what she described as barriers confronting overseas-qualified nurses in Australia, with a particular interest in nurses from non-English speaking backgrounds. Her study focused on issues related to language skills assessment, recognition of overseas qualifications, and post registration employment mobility. This thesis, on the other hand, focused on the vital transition between the recognition of overseas qualifications and post registration employment, namely the educational experiences of the nurses during the CBAP.

Hawthorn (2001) examined the following databases:

- A detailed study of 719 overseas-qualified nurses (OQNs) including narrative accounts of the nurses’ experiences
- Census on nursing employment 1991 and 1996
- Department of Immigration and Multicultural Affairs statistics
- Pre- and post- migration OQN assessment outcomes provided by the Australian Nursing Council Incorporated (2000)

Hawthorn concluded that, amongst other things, the introduction CBAP represented a significant reform in relation to competency assessment for NESB nurses with a 90-95% pass rate in Victoria. However, Hawthorn found that although NESB nurses generally secured professional employment following registration, there was persistent labour market segmentation for some groups of NESB nurses over time, with East European and non-Commonwealth Asian nurses disproportionately concentrated in the aged care sector; a claim that raises
some concerns in relation to skill utilisation. Hawthorn also reported in the same work that many NESB nurses spontaneously reported a serious and discomforting level of Australian nurse peer rejection.

Such adjustment issues, Hawthorn argues, have not received sufficient policy attention to date, despite their potentially profound impact on workforce cohesion and supply. This is relevant in this thesis to the extent that it highlights the need for further studies to focus more closely on the adjustment issues experienced by non-English speaking nurses, particularly as they enter the complex and intersecting systems of nurse education and employment in Australia.

Jackson (1995) conducted a significant phenomenological study in New South Wales with a small group of female graduates of a bridging program. That study focused on the everyday experiences of the participants in the hospital environment as qualified nurses. This was in contrast to this study, which examined the perceptions of NESB nurses of their educational experience whilst enrolled in CBAP and was not restricted to female participants. The findings of Jackson’s (1995) study revealed a considerable degree of discomfort on the part of participants in relation to their entry to the health system. Some of the factors that impacted on their professional adjustment were unfamiliar roles; and intolerant, obstructive and sometimes hostile behaviour (Jackson, 1995: 34; NRNE 2002). In commenting on these findings it is noted in the NRNE (2002) that the need to promote culturally appropriate and safe environments extends beyond patients and clients, and that nurses should make an investment in fostering the same culturally supportive environment within their own workplace.

Josipovic (2000) conducted a descriptive ethnographic study with a group of NESB nurses who had participated in a CBAP between 1991 and 1993 and found
that NESB nurses believed that there needs to be greater recognition of their prior learning and language skills in order to maximise the utilisation of available resources in Australia.

**Culturally Sensitive Curriculum**

The review of the literature also revealed significant concern with the development of culturally sensitive curriculum in undergraduate nursing programs (Campina-Bacote et al., 1996; Josipovic, 2000; Kanitsaki, 1988; Leininger, 1996; NRNE 2002; Omeri, 2004) and with the perceptions of students enrolled in undergraduate programs in relation to their educational experiences on campus and in clinical placement (Gorman 1999).

Gorman’s study was a qualitative investigation of the experiences of non-English speaking background students enrolled in an undergraduate nursing program and the faculty members who taught them. Gorman’s investigation identified a number of cultural factors that he believes may be relevant in varying degrees to most students of nursing from non-English speaking backgrounds. The most relevant of Gorman’s findings in relation to this work were that:

1. While cultural beliefs and values were noticed by both academic and clinical staff, behaviours were most often noted to be problematic in the clinical environment.

2. Behaviours were rarely attributed to cultural differences, particularly by clinical staff. This, according to Gorman resulted in students being viewed as non-assertive, retiring, overly respectful of authority figures, and reluctant to engage with others by disclosing personal information and sharing experiences.

All of these factors were seen as faulty interpersonal skills which, it was believed, could result in the student being seen as incapable of functioning competently as a nurse. In other words, difference equals problem. Importantly too, Gorman
noted a marked contrast in the expectations of faculty staff versus those of clinical nurses. Whilst faculty staff favoured challenge from students in order to enable them to become autonomous self-directed learners, clinical nurses on the other hand expected students to comply with professional norms without question. This study served to gain an understanding of the educational experiences of overseas-qualified nurses from NESB seeking pre-registration education in Victoria.

**Non-English Speaking Nurses in the Australian Workforce**

Pitman and Rodgers (1990:a) conducted a two-part survey among nurses practising in the state of Victoria. Both studies focused on nurses who were in the work force at the time the study was conducted. The primary aim of this study was to assist with the recruitment of multilingual and bi-lingual students into nursing, and to provide baseline information for multicultural nursing. This was, by all accounts, patient focused. It was also intended to assist with the recruitment of nurses into various health care settings.

The response rate was only 26% and that included nurses for whom English was their first language, although the percentage of English speaking respondents was not indicated in the report. The study explored the views of nurses who were already in the workforce in Australia or who had been at a point in time. And, similar to Hawthorn (2001), the study focused mainly on experiences with skill recognition to and following professional registration

The most important barriers to professional socialisation reported were: the discriminatory attitudes of other nurses, (with Asian nurses reporting the greatest difficulty in this regard); difficulty acquiring registration, and learning new professional practices. Project Two was an adjunct to Project One (Pitman and Rodgers, 1990). However, it was less relevant to this study on the basis that
the respondents had actually qualified in Australia. It was a random survey of registered nurses resident in the Melbourne metropolitan area in order to find out what languages were spoken (other than English) by the respondents, with a view to establishing the participation levels of nurses from non-English speaking backgrounds in the nursing profession.

In this study from a sample of 5,565 there was a response rate of 42.2%. It was reported that one fifth of the sample (presumably of those who responded) spoke a language other than English fluently at home. The main disadvantages that these respondents reported (in relation to how ethnic identification affected their professional experiences) were associated with communication with patients and staff.

Both studies focused on nurses who were in the work force at the time the studies were conducted. In fact the latter group had qualified in Australia. The main finding, however, was that considerable ethnic diversity was found in the nursing profession in Victoria. This study focused on NESB nurses at the point of entry to nurse education and practice in the State of Victoria.

**Broader Political Context: National Level**

In 2001 nursing was ranked as the third target profession in Australia’s skill migration program (Hawthorn 2001) in a context of continuing attrition of local nurses (Cowin and Jacobsson, 2003; Hawthorn, 2001; Webcast, 2006).

**The Global Shortage of Registered Nurses: International Level**

Buchan and Calman (2005:1) provide a report on the global nursing workforce led by the International Council of Nurses (ICN), The Florence Nightingale International Foundation (FNIF) and the Burdett Trust for Nursing. The report examined crucial issues in relation to the shortage of nurses. According to these
authors the current scarcity of qualified health personnel, including nurses, is a major obstacle to achieving the Millennium Development Goals (MDG) for improving the health and wellbeing of the global population.

In exemplifying the magnitude of the problem, Buchan and Calman (2005:1) point to the concerns of international agencies such as the World Health Organization (WHO), World Bank, the Organization for Economic Co-operation and Development (OECD) and the Rockefeller Joint Learning Initiative, regarding what they describe as the huge and growing challenge of ensuring that one of the most critical components of the health workforce: nurses, is maintained. Described as the ‘front line’ staff in most health care systems, it is recognised that their services are essential to meeting the Millennium Development Goals through the delivery of safe and effective care (Buchan and Calman, 2005:1).

The importance of this report in relation to this study is that, as Buchan and Calman point out, failure to deal with the nursing shortage at local as well as at regional, national and global levels is likely to lead to a failure to maintain or improve health care. It is at the local level, at the intersection between health and education, in other words the context of nurse education in Australia, that this study is located.

The initial literature review then helped to provide what Cutcliffe (2000) describes as a feel for the issues at work in the subject area. It helped to highlight the fact although previous studies explored issues related to the experiences of NESB nurses in the health care sector and NESB students of nursing in the tertiary sector and the associated clinical education component, none of these studies explored the perceptions of NESB nurses of their learning experiences whilst enrolled in a CBAP.
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The most significant aspect of this phase of the literature review is that it highlighted the fact that the experiences of NESB nurses and undergraduate nurses of NESB in the current educational environment and health care settings were not good in terms of acceptance by peers and mentors. A further relevant factor that was clear from the literature review is the current shortage of nurses at the national and international level. In light of this knowledge it would seem that if the skills of NESB nurses are to be utilised as part of the solution to the global shortage of nurses then further research is needed in order to gain a detailed understanding of the major issues for NESB nurses who are enrolled in CBAP in order to improve the quality of the theoretical and clinical components of these programs.

2.3 Phase Two of the Literature Search

In keeping with the grounded theory approach, the second phase of literature searching took place when the theory was sufficiently grounded in the core variable: “Moving Toward Contextual Competence”. The themes that emerged from the data analysis and grounded in the core variable were: Teaching and Learning, Adaptation, and Experiencing Diversity. Imbedded in these themes were sub categories that related to intrapersonal, interpersonal, environmental, and social factors that simultaneously served to impede and expedite the move towards contextual competence.

It is worth noting here that the majority of NESB nurses who participated in the study had arrived in Australia within one month, and in some instances less than one month prior to the commencement of the CBAP. To that extent they took on many of the characteristics of international students in the tertiary education environment, a factor that made it imperative to relate literature in relation to the experiences of international students to the findings from this study in order to identify similarities and differences, thus enabling me to highlight the potential
relevance of the findings of those studies to the experiences of NESB nurses who are enrolled in CBAP.

2.3.1 Teaching and Learning

Teaching and learning was a major theme that emerged from the data in relation to the perceptions of NESB nurses of the learning experiences whilst enrolled in a CBAP. This necessitated a focus on learning on two distinct but interrelated environments, that is, the tertiary education system and the clinical learning environment situated in an acute care hospital setting. On reviewing the literature, it was considered appropriate to examine literature as it pertains to the views of international students of NESB and in particular international students of nursing. In addition, the literature that relates to the education of undergraduate nurses in the clinical environment was also considered relevant in order to compare and contrast the stated experiences of NESB nurses in that same learning environment.

Following the development of the core category and throughout the remainder of the study, a broad and complex body of literature was discovered. Some related in a direct way to this study, to the extent that it dealt in various ways with the experiences of international students of nursing. Some studies were American based, but nonetheless relevant in the Australian context. However, others were Australian based (Kilstoff and Baker, 2006). Other literature related to the study in a much broader sense and was useful in illuminating the political, contextual, organisational, and relational issues associated with the clinical and professional aspects of learning in the clinical environment (Herdman, 1998; Jones, 2002).

As previously stated much of the literature has been carefully analysed and synthesised in the relevant chapters in this work. As a result, the literature cited in this section will be restricted to placing the study in the broader context of
international student education (Amaro et al., 2006; Gorman, 1999; Kilstof and Baker, 2006; Omeri et al., 2003; O’Neill and Cullingford, 2005).

Literature that relates to adult learning in the workplace (Billett, 2001; Delahaye, 2005; Foley, 2004) and nurse education (Benner, 1984; Benner et al., 1996) will also be explored. This is in order to facilitate comparison of the experiences of NESB nurses in the tertiary based CBAP with those of international students in general and those enrolled in postgraduate and undergraduate programs of nurse education in particular. Reference will also be made to the general literature in relation to cultural adaptation (Doyle et al., 1996; Sanchez, Spcetor and Cooper, 2000; Schlossberg, 1981; Stoy, 2000; Ting-Toomey, 1995; and Ward, Bochner and Furnham, 2001). Finally, literature that relates to diversity in education and in the workplace will be examined (Cope and Kalantzis, 1997). There is a degree of overlap amongst the views of scholars who carried out studies with undergraduate and postgraduate student nurse populations of NESB in terms of their findings on issues of cultural significance in the educational and adaptation processes.

**International Students**

Global trends in internationalisation have influenced the mix of students traditionally occupying classrooms and skills laboratories in nurse education programs in Australia (Omeri et al. 2003). According to O’Neill and Cullingford (2005), international students in general face complex challenges associated with unfamiliar approaches to education as many of them are familiar with didactic approaches to teaching and learning versus more independent problem solving approaches encouraged in the Australian tertiary education sector. In addition, international students are faced with the need to adapt to cultural and social differences (Baker and Hawkins, 2006).
Students of nursing are particularly affected by these issues because the compulsory clinical education component of nurse education brings them face to face with the daily workings of the health care system and the culture of nursing in Australia. These encounters tend to intensify issues associated with learning, adaptation, and the experience of working with culturally and linguistically diverse populations (Kilstoff and Baker, 2006). It is suggested by Schlossberg (1981:3) that studying transition processes requires the simultaneous analysis of both individual characteristics and external occurrences.

A number of studies (Amaro, 2006; Kilstoff and Baker, 2006; Shakya and Horsfall, 2000) proved valuable in terms of facilitating comparison of the experiences of undergraduate students to those of NESB nurses who were enrolled in a CBAP. The work of Shakya and Horsfall (2000) revealed that the opinions of students about nursing curricula and teaching-learning processes do not constitute mainstream nursing knowledge in Australia. These authors deemed it important for the views of international students of nursing to be understood. It is suggested in this work that understanding the views of NESB nurses who are enrolled in a CBAP would be of equal value in terms of enabling quality approaches to the theoretical and clinical education of these nurses, thereby facilitating their professional learning and adaptation processes.

Most participants in previous studies experienced difficulties with various aspects of language (Amaro et al. 2006; Omeri et al., 2002; Shakya and Horsfall, 2000). Many reported that they experienced prejudice because of their accents (Amaro et al., 2006). These difficulties were related to technical aspects of language, that is, speaking and listening and interaction with teachers and colleagues. Learning a new vocabulary, as well as understanding new concepts, was deemed by Shakya and Horsfall (2000) to have the potential to impede the academic achievement of the NESB nursing student.
According to Phillips and Hartley (1990), this possibly relates to the belief that the bilingual person will rarely have equal ability in both languages. They suggest that communication anxiety can impact on academic behaviour with the result that a student who is apprehensive about communicating in a second language may avoid participating in classroom activities. This reluctance can also relate to the need to show respect by not speaking until spoken to (Shakya and Horsfall, 2000).

Gorman (1999) found that NESB students of nursing were more likely to encounter issues with communication in the clinical environment. A similar finding was observed by Amaro et al. (2006) who found that whilst the majority of international students of nursing reported that they did not experience prejudice or discrimination from their nursing teachers, many did encounter such behaviours from staff and patients in the clinical environment.

Here again the literature review points to empirical evidence that the experiences of NESB students of nursing generally are not favourable and this is particularly so in the clinical environment. This is a matter of concern given the significance of learning in the clinical workplace as it applies to nurses. It is also important if one is to consider the view that clinical learning is an essential part of quality (Stewart, Hanson and Usher, 2006) and patient safety (Benner et al., 1996). This will be discussed in greater depth in the next section.

2.3.2 Learning in the Clinical Environment
Learning in the clinical environment is recognised as an essential part of quality (Stewart et al., 2006), and nowhere is this more important at this time than in the delivery of quality nursing care. This is evidenced by the fact that job satisfaction studies in nursing indicate that conditions of nurses’ work are the most
important factors that determine the standard of nursing care (Braito and Caston, 1983; Gifford et al., 2002; Kelly, 2006; Rutherford-Dijkhuizen, 1995).

Two contemporary authors have critiqued the various learning theories and the underlying ideologies of their proponents through the nineteenth and twentieth century to the present (Delahaye, 2005; Foley, 2004). The works of these authors help to explain the significance of learning in the workplace, managing diversity, and strategic human resource development in the context of increasing globalisation. In addition, the works of Benner (1996) and to a lesser extend Billett (2001) help to give contextual meaning to the ideas of Foley and Delahaye in the realms of nurse education in the clinical environment.

According to Delahaye (2005:16), facilitating adult learning is fundamental to the existence of human resource development. A useful insight into the application of Delahaye’s view as it relates to the clinical environment is to be found in the work of Benner et al. (1996). Benner et al. note that nurses learn best in an environment where they feel free to ask questions without fear of negative responses. It is also suggested by Benner (1984) that there is no one set of characteristics that apply to all nurses.

It is posited by Rutherford-Dijkhuizen (1995) that foreign nurses are highly motivated and anxious to learn and be accepted. It is imperative then that the approaches to teaching and learning in the clinical environment are responsive to that level of motivation. It is argued in this thesis that improvement to the quality of education in the clinical environment needs to be considered in the light of the learning needs of NESB nurses with an understanding of the factors that create barriers to learning and applying existing skills.
Kilstoff and Baker (2006) found that NESB nurses in the clinical environment fear making mistakes, interacting with staff and are uneasy with the expectations of other health professionals. In addition, they have difficulty understanding and speaking English and need to translate English back into their native language in order to facilitate comprehension. It is suggested by these authors that faculty staff and hospital staff need to be aware that NESB nurses often require additional time for comprehension and processing of information during clinical deliberations.

Billett (2001) advised that meaningful learning in the workplace does not take place by chance, but rather where there is a meaningful workplace curriculum with supervisors who possess the skills and knowledge to act as facilitators of learning and the time to devote to the task. In addition, it is suggested by Fenwick and Tennant (2004) that people learn best by engaging in the activities of the community where they practice. The objective according to these authors is to become a full participant in the community of practice rather than to learn about the practice. This in turn facilitates the demonstration of knowledge through its application in real life situations; a form of learning that, according to Hird (1995), represents a distinct feature of competency based education.

The work of Rutherford-Dijkhuizen (1995:15) adds an interesting and explanatory dimension to the work of Fenwick and Tennant (2004), particularly as it relates to NESB nurses. Rutherford-Dijkhuizen refers to the theory of Maslow (1954). Maslow’s theory identified five basic hierarchical categories of human needs: physiological, safety and acceptance as lower needs; self-esteem and self-actualisation as higher needs. Rutherford-Dijkhuizen (1995) referred to the work of Herzberg et al. (1959) who proposed a two-factor needs theory that compressed Maslow’s five levels into two main categories of satisfiers and dis-satisfiers. This theory offered a more concise explanation of how job satisfaction
and dis-satisfaction result from different causes and cultural norms. It is suggested by Herzberg et al. (1959) that although lower level needs varied across cultures, higher level needs, that is, motivational needs remain unchanged by cultural differences. Positive factors in this regard were identified as peer recognition and increased responsibility. This fits with the views of Tennant and Foley (2004) and Chan (2001) who noted that the provision of learning opportunities in the clinical environment was more important than formal teaching. It is suggested in this work that unit managers hold a measure of control over this aspect of learning.

According to Andrews et al. (2006:865), unit managers play a significant role in influencing staff attitudes and actions toward nursing students and concurrently the quality of teaching that students encounter. Participants in this study (which was a joint study conducted by scholars based in the Canada and the United Kingdom) identified the ward manager as one of the key professionals that influences their learning experience.

It is acknowledged that many unit managers (NUM) work in an environment where a centralised hierarchical culture prevails (Stewart et al., 2006:13), and where the effectiveness of clinical governance is undermined by a continuing preoccupation with a top-down approach to performance management. In such a system the clinician manager is not at the forefront of deciding the best practice. This raises questions regarding the extent to which health systems reflect a clinical governance model aimed at safeguarding best practice in both clinical services and education (Stewart et al., 2006). Best practice, it is argued in this thesis, does not merely relate to patient care but also to the provision of quality clinical education in that environment, which in itself has direct implications for patient care (Braito and Caston, 1983; Gifford et al., 2002; Rutherford-Dijkhuizen 1995). Stewart et al. (2006:13) emphasise that learning in the clinical environment
should include, amongst other things, information on how best to work together, how to avoid and manage risks, and continuing professional education for all staff.

The findings of Omeri and Atkins (2002) and Kilstoff and Baker (2006) bear a high degree of relevance to this study to the extent that both groups of respondents in their studies were nurses of NESB who were originally qualified in their countries of origin and had first hand experience with learning in the clinical environment in Australia. Participants in the Omeri and Atkins (2002) study were not enrolled in a formal educational program at the time the study was conducted. Rather, these researchers utilised a phenomenological approach to explore the everyday experiences of immigrant nurses in the workforce. The study conducted by Kilstoff and Baker (2006), on the other hand, was an open ended descriptive survey that explored the participants’ expectations and perceptions of their learning experiences whilst enrolled in postgraduate studies in nursing in an Australian university as distinct from CBAP. That population differed from the population in this study to the extent that they had a far greater period of time to complete those studies and become acclimatised to the health and educational systems in the Australian context than do NESB nurses who are enrolled in a CBAP. This leads to the consideration of the concept of adaptation and the structures, processes, and experiences that facilitate it for NESB nurses.

2.3.3 Adaptation

According to Ward et al. (2001) interaction between culturally heterogeneous individuals and groups involves a variety of complex social and psychological processes. This and other studies offer a range of theoretical concepts (some overlapping) on factors that influence the adaptation process (Ting-Toomey, 1999; Ward et al., 2001). Amongst the factors mentioned are institutions such as educational facilities and places of work. These institutions according to Ting-
Toomey (1999:237) can either help or hinder the adaptation process through the degree of receptivity and helpfulness provided by members of the host community. This is a view that seems to resonate in the work of Ward et al. (2001), albeit their study represents a broader socio-cultural perspective in that it suggests that socio-cultural adaptation is strongly affected by contact variables such as quantity and quality of relations with host nationals.

For the purpose of this thesis the concepts put forward (Ting-Toomey, 1999; Ward et al., 2001) take on contextual meaning if they are considered in the light of other studies conducted on NESB nurse populations (Amaro et al., 2006; Davidhizar et al., 1999; Kilstoff and Baker, 2006; Omeri and Atkins, 2003; Shakya and Horsfall, 2000; Wickett and McCutcheon, 2002). According to Kilstoff and Baker (2006), international postgraduate nursing students wrestle with cultural gaps in adapting to clinical practice. These cultural gaps according to these authors can lead to misunderstandings and conflict. This view seems to be shared by Shakya and Horsfall (2000), who suggest that internalised culture has the potential to inhibit learning in an educational setting imbued with very different values and expectations. Similarly, Barnes (1996) argues that grounded theory researchers should not ignore the influence of culture if the emergent theory is to be relevant to the population under study.

Kilstoff and Baker (2006) pointed out that problems with cultural acclimatisation in the clinical learning space could possibly be reduced if hospital staff were encouraged to use approaches to facilitate the learning of international students. This could be achieved according to Kilstoff and Baker (2006) by clarifying abbreviations, medical terminology, pronunciations, slang and idioms, sharing the cultural norms of the clinical unit, offering assistance, sharing resources and providing positive feedback. It is also suggested that encouraging overseas qualified nurses to discuss health care practices in their countries of origin would
help, as well as inviting them to be part of the team (Josipovic, 2000; Kilstoff and Baker, 2006).

This is not to say of course that NESB nurses in this study did not encounter problems with the adaptation process in the theoretical component of the program but it seems that the issues that were reported were fewer and less concerning to the NESB nurses who were enrolled in a CBAP.

Gorman (1999) and Shakya and Horsfall (2000) stress that the expectation for students of nursing to communicate well with patients, registered nurses and other health personnel in the clinical environment creates negative reactions for students who have language difficulties. For example, Shakya and Horsfall (2000) point out that Australian nurses rarely listen for longer than ten minutes to someone whose pronunciation is difficult to understand. It will be recalled that studies discussed above (Ting-Toomey, 1999; Ward et al., 2001) stressed the relationship between adaptation processes and the degree of receptivity and helpfulness provided by members of the host community and the quantity and quality of relations with host nationals.

It is suggested by Wickett and McCutcheon (2002:51) that English language ability is one area that needs to be addressed, as covert discrimination could occur if there is a belief that English is the main determinant of competence. These authors suggest that it may be cultural issues that need clarification rather than language per se. The view of Barnes (1996), helps to explain the language difficulties from a broader perspective. Barnes (1996: 432) argues that language constitutes a logic, a general frame of reference, that moulds the thought of habitual users of that language. According to Barnes (1996) the Western system of language is based on Aristotelian logic and contains peculiarities such as subject and predicate, as well as extensive use of the verb to be, and the use of inference.
Barnes (1996) argues that in the Chinese language, for example, this logic is absent, making both direct translation of text as well as understanding the meanings problematic for Chinese learners. Understanding different systems of logic then may help to explain the self-proclaimed language difficulties reported by Chinese nurses in particular who were involved in this study. This idea, although used in this section to explain issues associated with language difficulties, is also likely to be inextricably linked to the sociology of diversity, an issue that will be discussed in the next section of this chapter.

The review of the literature in this area then has been of assistance in terms of providing an understanding of the institutional, cultural and relational factors that impact on the professional adaptation process for culturally and linguistically diverse people generally. More importantly though, it facilitated comparison of those experiences with the experiences reported by NESB nurses in this study as well as providing an opportunity to focus on issues that were unique to the NESB nurse population in this study. Finally, it highlighted the need for the education of nurses in the clinical environment regarding the complexity of the adaptation process and how that could be facilitated.

2.3.4 Diversity
The work of Cope and Kalantzis (1997) has provided a framework in which to view the concept of diversity in the health care workforce. Cope and Kalantzis suggest that diversity is neither a problem nor a matter of attitudes; rather, workforces are most effective when they are as diverse as the local and global environments in which the organisation is situated. However, Davidhizar et al. (1999) note that in the hospital workforce diversity, instead of being regarded as a potential source of creativity and improved problem solving, can often be a source of political strife and mistreatment of people. They suggest that such
organisational pathologies are often associated with unmanaged workforce diversity.

According to Cope and Kalantzis (1997) diversity management and multicultural communications are no longer optional extras, but rather core competencies for managers and workers in the context of rapidly disappearing mono-cultural and monolingual workplaces. Similarly, Covington (2001) notes that managers must be cognisant that NESB nurses are influenced by cultural factors as they relate to language, space, time, environment and social structure. Managers should be creative and willing to tailor leadership styles to encompass individuals from different cultures. This is because differences left unacknowledged, according to Gooden et al. (2001), can cause feelings of exclusion and culture shock.

In examining the implications of racial diversity for self-perceived communication effectiveness of nursing care teams, Dreachslin et al. (2000) developed a grounded theory based on the analysis of data collected from fourteen focus groups in two hospitals. Two major themes emerged that constitute an overarching framework within which racially diverse team members evaluated team communication effectiveness. These were: different perspectives, and alternative realities. The authors also found three additional themes that served as reinforcing factors: social isolation, selective perception, and stereotypes. The findings reported had important practical implications for health care delivery teams that are comprised of racially diverse team members. Effective diversity leadership was found to be the significant mitigating factor in team communication effectiveness and therefore increased attention to the development of team leaders is an essential component in terms of increasing the effectiveness of culturally diverse teams. However, according to Wells (2000) without an examination of the assumptions that underlie the organisational culture, changes instigated to ameliorate the organisational environment in
relation to cultural diversity will be more cosmetic than substantive; but change, it is argued, is necessary to move beyond individual and institutional rhetoric on cultural diversity (Wells, 2000:196). Gooden et al. (2001) sum this up well in expressing the view that nursing as a profession has accepted diverse people for care and that the profession now has the unprecedented opportunity to accept and support diverse caregivers.

2.4 Summary
This chapter has served three significant functions (1) it has outlined the process taken for the use of literature in the grounded theory approach and it has clarified that the literature in the substantive area was reviewed in two phases; (2) it has discussed why, in keeping with the constant comparative approach (which will be explained in greater detail in the next chapter), an exhaustive review of the literature was not appropriate prior to the commencement of the study. This approach was adopted because the focus of the study was not to test hypotheses, but rather to generate a middle range theory that has the potential to be utilised as a framework that may be used by the relevant stakeholders in order to improve educational processes for NESB nurses who are enrolled in CBAP. It is believed that this in turn has the potential to facilitate the identification and maximum utilisation of their specialist and generalist nursing skills; and (3) in keeping with the grounded theory approach the main themes or categories that support the core category, namely: NESB Nurses “Moving Toward Contextual Competence in Victoria”, have been identified. In each case relevant theories and concepts from the extant literature have been analysed and synthesised to demonstrate the contextual, professional, relational, and social significance of the categories that emerged from the constant comparative method in this study.
CHAPTER 3

METHODOLOGY
3.1 INTRODUCTION
This chapter will begin by providing a description of grounded theory methodology and the rationale for the selection of a grounded theory approach as a means to investigate the topic of this thesis. The evolution of grounded theory and the ongoing scholarly debate associated with the method will be discussed. The chapter will include a description of the following: timing and context of the study, ethical issues, access, the sampling and selection process, cross cultural issues associated with data collection and interpretation, the development of an initial set of concepts to facilitate data collection in the early stages of the research, the methods of data collection and a detailed description of, and justification for, the strategies and methods, and finally, a discussion is included on how data collection and analysis occurred simultaneously for the most part, with a more refined and detailed analysis of the data occurring towards the end of the study.

3.1.1 Grounded Theory
From a historical perspective, grounded theory emerged from the works of Glaser and Strauss (1965; 1967) and has been described as being at the front of the "qualitative revolution" (Charmaz, 2003: 250). According to Strauss (1987), two streams of work and thought contributed to this development. The first was the general thrust of American Pragmatism and in particular the works of Dewey Mead and Pierce which included emphases on action, the problematic situation, and the need for conceiving of method in the context of problem solving. The second stream of work was based in the tradition of Chicago Sociology from the 1920s to the 1950s, a tradition in which interviews and field observation were utilised as data collection techniques. Both philosophical and sociological streams, writes Strauss (1987), assumed that change is a constant feature of social life but that its specific directions need to be accounted for. These streams placed social interaction and social processes at the centre of attention. According to
Charmaz (2005), grounded theory refers to both a method of inquiry and to the product of inquiry. However, Charmaz states in the same work that it is generally referred to as a method for analysing data.

According to Charmaz (2003:250), the pioneering researchers (Glaser et al., 1992; Strauss, 1987; Strauss and Corbin, 1990, 1994, 1998) have moved the method in somewhat conflicting directions, but contends that all of their positions remain imbued with positivism, that is, with assumptions of a neutral observer who discovers data, objective external reality, reductionist inquiry of manageable research problems, and objectivist rendering of data. However, Charmaz (2003) suggests that in the works of Strauss and Corbin (1990, 1998) there is a movement into a post-positivist approach because they propose giving voice to their respondents. This Charmaz (2003:250) suggests takes the approach into the constructivist paradigm with its assumption of the relativism of multiple realities and the recognition of mutual creation of knowledge by the viewer and the viewed, and aims toward interpretative understanding. Nonetheless, Strauss and Corbin (1998) stress that many of the essentials of the original method have been maintained.

Charmaz (2005) argues that in the past the major statements of grounded theory minimised the interpretative/constructivist inflection. Charmaz suggests that in order to develop grounded theory in the 21st century it is important to build on the constructionist elements of the method. It is argued that the power in grounded theory lies in the tools it provides for understanding empirical worlds (Charmaz, 2003). Charmaz claims that these tools can be reclaimed from the positivist underpinnings to form a revised open-ended practice that stresses its emergent constructivist elements.
Alternatively, Glaser (2001, 2002) describes constructivist grounded theory as a misnomer that remains to be figured out in terms of its philosophical underpinnings. Herein lies the major point of divergence between the views of Glaser and those of Strauss and Corbin. Glaser (1992) claimed that Strauss and Corbin’s version no longer permitted theory to emerge from the data, but provided for a full conceptual description which forced the data and theory rather than allowing emergence (Eaves, 2001). Glaser (2001:1) claims that: “there is no such thing for grounded theory as bias data or subjective or objective data or misinterpreted data. It is what the researcher is receiving, as a pattern, and as a human being” and Glaser claims that this is inescapable.

Strauss and Corbin (1990a:22), on the other hand, claim that a developed grounded theory is a rendition of “a reality that cannot actually be known, but is always interpreted”. However, there remains considerable overlap in the views of these authors, although in essence the constant comparative method remains as well as the ideological motives for its use.

According to Glaser and Strauss (1967), grounded theory is discovered, developed and provisionally verified through systematic data collection and analysis of data pertaining to a particular phenomenon. Glaser (2002:1) sums it up this way. He states that:

All is data. It means exactly what is going on in the research scene, is the data [sic], whatever the source, whether interview, observations, documents, in whatever combination. It is not only what is being told, how it is being told and the conditions of its being told, but also all the data surrounding what is being told. It means what is going on must be figured out exactly what it is to be used for, that is conceptualization, not for accurate description. (Glaser 2002:1) [On-line]
Eaves (2001) and Holloway and Wheeler (2002) state that grounded theory is a qualitative interpretative approach that grew out of the symbolic interactionist tradition. Symbolic interactionism is both a theory about human behaviour and an approach to inquiry about human conduct and group behaviour (Annells, 1996). It focuses on actions and perceptions of individuals, their ideas and intentions (Holloway and Wheeler, 2003; Taylor, 2006). This fits with the Chicago Sociology tradition of emphasising the necessity for grasping the actors’ viewpoints for understanding interaction, process and social change, and grounding theory in action (Strauss and Corbin, 1997).

This study focused on perceptions of the participants and therefore the grounded theory methodology provided an appropriate set of assumptions to investigate the question because of the usefulness of the approach in terms of helping to explain relatively unknown situations (Stanley and Cheek, 2003; Taylor et al., 2006).

**Grounded Theory and Symbolic Interactionism**

The work of Blumer (1969) helps to delineate the relationship of grounded theory to symbolic interactionism which is the theory from which grounded theory research method arose (Annells, 1996), and thus the usefulness of the method to explore a phenomenon about which little is known. Blumer cited three basic premises of symbolic interactionism. They are as follows:

1. Human beings act toward things on the basis of the meanings that the things have for them. Things may include objects, other human beings, institutions, ideals beliefs, activities of others and situations

2. The meaning of such things is derived from, or arises out of, the social interaction that one has with one’s fellows
3. The meanings are handled in and modified through an interpretative process used by the person in dealing with the things he encounters (Blumer, 1969:2)

In keeping with the guiding principles of symbolic interactionism, a grounded theory approach was used to explore the perceptions of non-English speaking nurses of their educational experiences whilst enrolled in a CBAP. This was achieved through gaining a detailed account of their perceptions of their learning experiences whilst enrolled in a CBAP and what they deemed to be problematic about that process.

According to Strauss (1987) grounded theory is a style of qualitative analysis that includes a number of distinct features such as theoretical sampling and methodological guidelines, for example, making constant comparisons, and the use of a coding paradigm to ensure conceptual development. Glaser and Strauss (1967) state that the method can be used for social units of any size. Grounded theory is, according to Annells (2003:166), usually context dependent. It is most likely to be a middle-range theory that is more than a working hypothesis but not an all inclusive grand theory. A developed grounded theory, therefore, may be about seeking a solution to a problem in practice. Above all it should be grounded in the data (Amaro et al., 2006; Dreachslin et al., 2000; Mertens, 1998; Stanley and Cheek, 2003; Tuettemann, 2003).

In commenting on the method, Stern (1980) and Charmaz (2006) emphasised the flexible nature of what is described as guidelines rather than a set of methodological rules. The process is non-linear with the investigator focusing the research according to a conscious selective process. Thus the researcher and the researched are, in the words of Caulley (1994: 3-20), “bound together”.
Charmaz (2006) refers to grounded theory method as a craft that researchers practice. However, the method has also been described as an art form (Sandelowski, 1995). One can consider the practical application of the method as the craft and the artistic form being about communication and experience, as suggested by Dewey (1934, 1958) cited in Janesick (2003). The combination of art and craft then requires much patience and dedication throughout the process. However, the process proved to be extremely valuable in terms of the quality of information gained, with NESB nurses providing detailed accounts of their perceptions of their educational experiences, the social and cultural interpersonal and intrapersonal factors that impacted on those learning experiences, and what that meant for them.

The primary purpose of grounded theory then is to generate explanatory theories of human behaviour (Strauss and Corbin, 1990). In other words, the method aims to generate theoretical constructs that explain the action in the social context under study (Stern, 1980). Lincoln and Guba (1985:41) posit that no priory theory could possibly encompass the multiple realities that are likely to be encountered because *a priori* theory is likely to use priori generalisations that are unlikely to be an idiographic fit for the situation encountered. This view is supported by that of Maykut and Morehouse (1994) who suggest that human beings are too complex to be captured by a static one-dimensional instrument. In grounded theory, data collection, sampling, and analysis occur simultaneously as the study progresses and sampling and further data collection are based on emerging theory rather than on a preconceived theoretical framework (Glaser and Strauss, 1967) and this is precisely the approach that was adopted in this research.
Chapter 3

Methodology

The Role of Literature

The role of literature has already been discussed in the previous chapter therefore only a brief outline will be included here. Glaser (1992:31) stresses that the dictum of grounded theory is:

“There is a need not to review any of the literature in the substantive area under study... Grounded theory is for the discovery of concepts and hypothesis, not for testing or replicating them”.

By contrast, Strauss and Corbin (1990), Rossman (2003), and Annells (2003) suggest that the literature can be used to guide the research procedure in a variety of ways such as: establishing the significance of the research in the light of current knowledge derived from research in the area; developing questions to guide the initial data collection and observations; and enhancing theoretical sensitivity. This signifies a point of difference between the views of Glaser (1992) and those of Strauss and Corbin (1990). In this study some theoretical sensitivity was gleaned from the first phase of the literature review particularly the views of Benner (1984). However, in qualifying Glaser’s view, the avoidance of using literature only applies at the beginning of the research process and as soon as the theory seems sufficiently grounded in a core variable, and there is an emerging integration of categories and properties, then a review of the literature in the substantive area is appropriate in order to relate the literature to the researchers’ own work.

3.1.2 Rationale for Grounded Theory

There are several features of the grounded theory approach that make it an appropriate method of enquiry for this study. Firstly, grounded theory makes its greatest contribution in areas where little research has been conducted (Glaser, 1992; Stanley and Cheek, 2003; Stern, 1980; Taylor et al., 2006), as is the case with overseas-qualified nurses from non-English speaking backgrounds, in particular
those who are enrolled in a CBAP. It is argued by Stern (1980) that where no theory regarding a situation exists, then it is impossible to test theory. It is further argued by Gumesson (1991) that human beings in work situations are unique and for that reason it is likely that existing theory will prove inadequate for new investigations. This is particularly so if one is to consider that symbolic interactionism holds that people are in a continual process of interpretation and definition as they move from one situation to another (Eaves, 2001:652).

Grounded theory was chosen over Ethnography because the study was not intended to focus solely on cultural practices, beliefs and values of the community under study (Creswell, 1998; Mertens, 1998 and Morse and Field, 1995), but rather on their day-to-day experiences in the educational environment in order to generate a theory or explanation about those experiences (Creswell, 1998). It is noted by Stern (1980) that cooperative inquiry is useful in the exploration of context dependent work because it enables the investigator to examine processes that are happening in the social scene.

Phenomenology would have provided an opportunity to emphasise the subjective experience of a number of individuals (Creswell, 1998; Mertens, 1998). However, it would not permit exploration of important broader contextual issues (Langridge and Ahern, 2003). Grounded theory, on the other hand, because it is based on symbolic interactionism (Eaves, 2001) does not have theoretical propositions stated at the outset of the study (Mertens, 1998); is process orientated; and provides an opportunity to gain detailed accounts of the situation in which individuals interact, take actions, or engage in a process in response to a phenomenon (Creswell, 1998). It thus enables the researcher to understand the ‘lived experiences’ of the respondents (Eaves 2001; MacIntosh, 2003; Yamona, 1999) as well as being able to apply this knowledge to a broader context.
Grounded theory has been utilised frequently in health care research (Eaves, 2001; Glaser and Strauss, 1967; Morse and Field, 1995; Strauss and Corbin, 1990). It has also been used in social research (Stern, 1980) with a view to discovering how people deal with situations and relationships. More relevant to this study, however, is the fact that strategies from the method have been previously utilised in relation to the education of student nurses of NESB to develop a grounded substantive theory that can be used to explain processes of managing the teaching of ethnically diverse nursing students, as well as making explicit the consequences of educators actions for students (Amaro et al., 2006; Yoder, 1996). It has also been utilised with undergraduate students of nursing (UK study) to investigate how their educational program prepared them for practice (Donaldson and Carter, 2005).

Some classical views of the method advocate the analysis of social processes and basic psychological processes (Charmaz, 2006) as being an integral approach to the grounded theory method. However, Glaser (2002) claims that to focus exclusively on these processes forces fit on the data rather than allowing the concepts to emerge. Whether as a result of Glaser’s claim or not, the method has been used in more recent times to investigate the social milieu of organisations (Connell et al., 2004), and to develop explanations for complex social phenomena manifested internally in organisations (Dreachslin et al., 2000; Yamona, 1999). An additional reason for the emergence of this trend may relate to the view that the conditional matrix (Strauss and Corbin, 1990) ensures that macro-social factors need to be considered as possible conditions influencing social interaction (Annells, 1996). The previous application of the method to develop explanations for complex social phenomena should create a degree of sensitivity to the importance of macro-social factors in this research, in particular the global context of the frameworks the NESB nurses bring to their study and their clinical practice, the complexity of the clinical learning environment, and the need for
teaching and clinical staff to be aware of, and sensitive to, the global dimensions of communication. The approach to the use of the grounded theory method in this study leant more toward the Strauss and Corbin (1990, 1998) inflection with the emphasis on the interpretative constructivist paradigm than that of the classical Glaserian version of the method (Glaser 1992).

3.1.3 The Context and Timing of the Study

In the interest of protecting the identity of the participants the precise dates when the study took place will not be revealed. This is because programs of this nature are limited in Victoria and the numbers who partake are relatively small, therefore there is a likelihood that participants could be identified if dates were to be provided. For this reason it is suffice to say that the data was collected during the 2004-2005 period.

The study population consisted of non-English speaking nurses who were enrolled in CBAP at two universities based in the state of Victoria during the time that data were collected. The study population was not divided into two cohorts due to the fact that there are only a small number of universities that provide CBAP and there is a risk of identification of participating institutions and of individual participants were concise distinctions to be made in terms of program characteristics.

The study also involved two teaching staff who were directly involved with the clinical supervision and education of the nurses during the period of clinical placement. A third teacher was involved with the theoretical component of the CBAP but, at an earlier time, had also been involved in the clinical education of nurses enrolled in a CBAP.
Data were also collected, for the purpose of triangulation, from an Australian born and educated nurse who was undertaking the program in order to regain professional registration following a considerable break from professional practice.

As stated earlier, the program is divided into two components: the theoretical component and the clinical component. The theoretical component is taught at the university and includes lectures, seminars, clinical simulation and an opportunity for participants to engage in self-directed learning activities. The clinical education component of the program is situated in a hospital, and at times it becomes necessary for the nurses to receive that component in two separate institutions. This is due to issues associated with the high demand on hospitals for the provision of clinical education for undergraduate nurses which includes NESB nurses who are enrolled in CBAP.

The context of this study, particularly in the clinical environment, was to a certain extent complex (Yamona, 1999) and lacked transparency for the observer because of privacy and confidentiality regulations in relation to consumer rights in health care settings (Johnstone, 1999; Staunton and Chiarella, 2004), group dynamics in the workplace (Owens, 1986), and a diverse range of motivations and aspirations on the part of respondents. The grounded theory method in these circumstances helped the researcher to discover dominant processes (Stern, 1980:21) in the clinical education setting, through the use of various forms of data collection, including, interview, observation, and the use of reflective journals.

**3.1.4 Ethical Considerations**

Ethical considerations were based on the theoretical perspective of Ethical Principleism: the most commonly used perspective to guide standards of conduct in health care, it is based on the principles of beneficence, non-maleficence,
autonomy, and justice (Johnstone, 1999; Staunton and Chiarella, 2003). Participants in this context, refers to individual informants, that is, non-English speaking nurses, teachers, participating universities and hospitals, and the nurse who acted as a “Discriminant Case” whose first language was English.

**Beneficence**

Beneficence in practice according to Johnstone (1999) entails a positive obligation to act for the good of others and can include, amongst other things, altruism. This principle in this research is grounded in the intention to utilise the research findings for the greater good.

**Non-maleficence**

Non-maleficence refers to the obligation to do no harm (Johnstone, 1999). In the context of this research this principle relates to such issues as the protection of the participants’ identity, both individuals and organisations, the individual’s right to be informed regarding the nature and purpose of the research, the voluntary nature of participation, and the right to withdraw at any time.

**Autonomy**

This refers to the right of the individual to exercise choice (Johnstone, 1999; Mills and Gale, 2004). In this case the choice of whether to participate in the research or not, in other words, voluntary participation and informed consent. Informed consent means that the prospective participants should know the exact nature of the research prior to deciding whether or not to participate (Mills and Gale, 2004). Participants should also be aware of their right to withdraw or limit the information provided to the researcher at any time.
Chapter 3

Methodology

Justice

Justice, according to (Staunton and Chiarella, 2003), has two meanings in ethics: justice for fairness in terms of equal distribution of burdens and benefits; and, justice in terms of equal distribution. Justice for fairness is the meaning most applicable to the treatment of participants in this research and related to each participant being treated fairly in terms of being provided with an opportunity to provide or withhold information without fear of being disadvantaged in terms to educational and assessment processes or in relation to professional opportunities following graduation.

The application for ethics approval to La Trobe University was guided by and reflected the ethical standards discussed above. The information to participants and informed consent process used in this study is outlined in Appendix 2 and 3. Ethics approval was obtained from La Trobe University (Appendix 4), which is where this study was supervised, and from participating universities and hospitals on the understanding the identities of all participating universities and hospitals and students (NESB nurses) should remain confidential.

Situational judgements were made in situ on a day-by-day basis in relation to what was appropriate in a particular circumstance in terms of seeking information during observation sessions in an acute care clinical setting and during interview sessions.

3.2 Techniques and Methods

The literature was reviewed in relation to the area of interest. This review was conducted in two phases. The first phase was part of the preparatory work and it was found that up to the time of this study no previous research had been conducted in this way in Australia involving non-English speaking nurses who were enrolled in CBAP. However, there were a number of studies conducted in
related areas. According to Morse and Field (1995:143) no study exists in isolation
and research must be embedded in the conceptual world as well as in the
research context. These authors do, however, share the views of Glaser (1992) in
relation to the importance of keeping the literature in abeyance and separate
during the process of data collection to prevent contamination: the participants
categories may not be identical to well established concepts described in the
literature and therefore labels should be collected cautiously (Morse and Field,

The initial data collection was guided by my personal brainstorming. This was
facilitated by previous professional association with overseas qualified nurses of
non-English speaking backgrounds. This was of considerable value in shaping
what Strauss and Corbin (1990) refer to as theoretical sensitivity and Gummesson
(c2000) refers to as pre-understanding. This helps the researcher to be aware of
the subtleties of the meaning of data, and to separate what is significant from
what is not. Berg (2004) suggests that insights and general questions about
research derive from previous experience with the study phenomenon. This view
seems to be supported by Miles and Huberman (1994:38) who suggest that some
familiarity with the phenomenon and setting under study is at least one marker
of a good qualitative researcher as instrument.

The final strategy prior to deciding on the initial concepts and themes was to seek
the assistance of five non-English speaking nurses who had completed a CBAP
within the previous twelve months in order to seek their opinions regarding
issues that were of central importance to them during the course of their own
study. It was believed that it was important that the volunteers were relatively
recent graduates in order to ensure, as far as possible, that issues that they
regarded as significant during their period of enrolment were still relatively fresh
in their memories and likely to be relevant to those who were enrolled during my own study.

I spoke informally with five people who had completed separate courses at different times in the previous year, one male and five females. Two of the volunteers chose to meet and speak with me individually, and three requested a group meeting. It was explained to all volunteers that their participation was purely voluntary. A description of the study, the aim of the study, the purpose of the study, and how their involvement would be of assistance, was provided. All volunteers were assured that the information they provided would be treated with the strictest of confidence and that their personal identity would remain anonymous. No payment or other inducements were offered to the volunteers.

In the case of the nurses who spoke individually, an open-ended approach to questioning was adopted, encouraging a more narrative style. These interviews were not taped, as it was feared at that time that the presence of a tape recorder might have impacted on the style and frankness of their responses, rather notes were taken during the interviews. The remainder of the volunteers, three female nurses, requested that they be interviewed as a group. In part, this may have related to their busy professional lives at the time and their availability as a consequence of that. This interview was taped. It had characteristics similar to a focus group interview (Berg, 2004:123), although it was not deliberately intended to set it up as such. The main problem with this interview was that participants had a tendency to speak together on issues that were important to them. This made it difficult to understand, in terms of accent and body language, and I felt that at times I missed out on meaning.

Through reviewing the recording however, much of the meaning was picked up; and in addition, valuable insights were gained regarding my own approach to
the interview process. During that initial interview, for example, it was observed that I adopted many of the characteristics of the clinical interview such as an authoritative voice tone, and that, I believed, was inappropriate for the data collection interview where a more narrative style of response from the interviewee was more desirable than answers to specific questions. In both cases valuable insights were gained regarding the phenomenon, which was of seminal value in guiding my initial data collection, and, increased mindfulness of my own influence on the process of generating data.

3.2.1 The Main Study
In the main part of the study, a variety of data collection techniques were used including semi-structured interviews, and informal conversation before, during, and following direct observation. A notebook was provided for each participant with a request that they document issues and incidents that they regarded as being significant in their day-to-day experiences in the educational setting. According to van Manen (1990), a journal can help a person to reflect on significant aspects of past and present life. A more detailed explanation of these methods will be provided later in this chapter. Permission was obtained from the Department Heads of two Schools of Nursing based in the state of Victoria to interview and observe small groups of participants who were enrolled in the CBAP for overseas-qualified nurses. Gaining access was not a difficult process.

3.2.2 Selection Process
An introductory seminar was held for all course participants and interested staff at both universities soon after the commencement date of the course in order to provide detailed information to the group regarding the nature and purpose of the research.
In order to gain information about issues of central importance to the research topic a theoretical sampling technique was to be applied. The guiding principles of this technique were explained in relatively simple terms to prospective participants in order to avoid a situation where some participants may feel abandoned later in the project if they were not chosen for ongoing observation and interview sessions. Written consent was obtained from each person who volunteered to be involved in the project. Participants were aware that they could withdraw from the project at any time.

The final definition of the sample was not reached prior to the beginning of the study, rather, decisions were made during the course of the study as to the relevance of the activity or the individual in terms of the emerging theory (Caulley, 1994; Glaser and Strauss, 1967; Lincoln and Guba, 1985; Mertens, 1998).

The theoretical sample was selected following some field investigations and interviews that involved all volunteers (Berg, 2004) in order to select information rich cases. There was a total of twelve NESB in the final sample. The nurses came from a broad range of cultural and linguistic backgrounds namely: India, China, Philippines, El Salvador and The Czechoslovakia, socialist Republic. They ranged in age from twenty five to forty five years.

A brief questionnaire was developed to collect information (Mertens, 1998:262) on the basic demographic characteristics of the group (Appendix 5). Points of interest that emerged from the quantitative data served as an additional guide for the selection of cases that seemed to be theoretically most interesting (Dawson, 2002; Mertens, 1998). This method of selection provided an opportunity to identify variations and common and diverse patterns among participants (Creswell, 1998). This was important with the population in this study on the basis that wide variations frequently exist in relation to age, culture, educational
background, professional education, identity and experience, linguistic competence, and the length of time the participant has resided in Australia.

In addition to the demographic data, the use of grounded theory methodology requires a sampling of human interactions and behaviours that are relevant to the study (Lincoln and Guba, 1985; Mertens, 1999; Whisker, 2001). Therefore, decisions regarding the sample were ongoing as the study progressed and more salient aspects of the situation were identified during the interview and observation process, and the inquiry focused more sharply on those (Lincoln and Guba, 1985:234). The process was also based upon the relevance of an activity or an individual in terms of emerging theory (Creswell, 1998:119). In some instances personal hunches regarding whether or not an individual would be theoretically interesting based on the demographic data did not hold up in the practice and the scope of data collection was then widened to include new informants.

An interview schedule (*aide memoire*) was prepared with a view to focusing on a small number of predetermined concepts (Glaser and Strauss, 1967). I was at all times cognisant of the fact that beyond decisions regarding the initial collection of data that further collection cannot be planned ahead of the emerging theory (Strauss and Corbin, 1967). I was not concerned then with asking exactly the same questions of each respondent; but instead with gleaning quality information regarding each individual’s perceptions (Edwards, 1993:194; Mishler, 1986:118) in the educational environment with a view to developing the next set of research questions based upon the previous answers (Glaser and Strauss, 1967).

**The Interview Schedule**

The interview schedule was flexible and subject to ongoing negotiation throughout the data collection period because of occasional roster changes
experienced by participants, issues with travel and family commitments, and the need to constantly evaluate the most appropriate use of the data collection opportunity between participants at various locations. Although the participants who were the subject of observation were all allocated to the same clinical venue, interview data was being collected from participants at other clinical venues during the same period of time.

The timing of the first interview in relation to the length of time the NESB nurse had been in the course depended on a number of factors, namely: the availability of the participant and access to the clinical venue in terms of an appropriate space in which to conduct an interview. However, most participants were interviewed within the first month of the course, except for two who experienced significant issues with travel arrangements and found it difficult to allocate time before the commencement of, or at the end of, their shift.

In some cases participants were interviewed in the first week of the clinical component while others were approximately one month into the clinical placement. Some were interviewed more than once and at various stages during the program as well as shortly after completion. The reason for the variation was mainly related to two factors: theoretical sampling (Strauss and Corbin, 1990) and availability of the participants. For example, some wanted to wait until they had completed a particular examination believing that interview time would impact on their study time. This was not an unreasonable assumption given that some participants travelled up to eighty kilometres each day to and from the clinical venue by public transport. Nonetheless, there were occasions when the reasons the NESB nurses put forward for wanting to delay the interview process in itself made them theoretically interesting because of the strength and educational relevance of their requests to delay the process; for example the scarcity of study time and the demands of travelling time.
The window of opportunity for data collection was relatively short. This was a mixed blessing, on the one hand it left very little time to analyse data immediately following each individual interview. On the other hand, however, it meant that the entire experience of data collection was an intense process and this created an increased theoretical sensitivity. This is an important creative aspect of the grounded theory approach according to Strauss and Corbin (1990) because of the repeated and intense nature of contact with the participants; in this case it provided and a heightened awareness of the emergent issues. Observation sessions proved to be an invaluable adjunct to interviews during this period of intensity providing an opportunity to quietly stand back and observe, and to compare and contrast what was seen with what was heard.

3.2.3 The Context of Interviews
Interviews were arranged by mutual agreement during the course of the CBAP, either before the participant commenced a clinical nursing shift in the case of an afternoon shift, or immediately following a shift in the cases where the participant worked a morning shift. There were two motives for this timing: firstly, to avoid unnecessary travel on the part of participants, and secondly, to ensure that the participant was sufficiently close, in terms of timing, to the naturalistic setting so that thoughts, feelings, and images of the learning and socialisation experience were still likely to be at the forefront of their thoughts and feelings. These considerations were applied both in the case of those participants who were involved in direct observation and those who were not observed in clinical practice. The significance of this approach in this and in every other aspect of this study is that it invokes the core principles of post-positivist interpretive inquiry (Caulley, 1994). These are as follows:
Naturalistic setting

The phenomenon is studied in context and there is likely to be some degree of transferability from one natural setting to another and the researcher must consider all the factors and influences in the context being studied.

The human as instrument

The human instrument, it is argued by Caulley (1994) and Janesick (2003), has the characteristics to deal with the complexity of human phenomena. Caulley referred to the work of Guba and Lincoln (1981) to explain these characteristics:

Responsiveness. The human-as-instrument can sense and respond to all personal and environmental cues that exist. By virtue of that responsiveness it is argued the researcher can interact with the situation to sense its dimensions and make them explicit.

Adaptability. The human is infinitely adaptable

Holistic emphasis. The world of any phenomenon and its surrounding contexts are “all of a piece”, and the human instrument is the only one available capable of grasping all this buzzing confusion in one view.

Knowledge beyond the stated: The human instrument can be sensitive not only to what is stated and overt in human relationships but also, the un-stated and covert.

Processual immediacy. Refers to the ability of the human instrument to process data just as soon as they become available, to generate hypotheses on the spot, and to check those hypotheses with respondents in the very situation in which they are created.

Opportunities for clarification and summarisation. The human instrument has the unique capability of summarising data on the spot and feeding them back to a respondent in the very situation in which they are created.
Opportunities to explore atypical or idiosyncratic responses. The atypical response has no utility in a paper and pencil instrument, conversely, the human instrument can explore such responses. (Adopted from Caulley, 1994:3-20)

3.2.4 The Interview Style

The interview style was based on what Minichiello and Anoni et.al. (1990), refer to as the Recursive Model. This line of questioning relies on the process of conversational interaction itself, and in so doing, allows the interview to follow a conversational tone and provides an opportunity to treat people and situations as unique. The interaction in each interview, argue Minichiello and Aroni et al., directs the research process.

The initial interview with each participant included an explanation of what I wished to achieve, that is, the perceptions of the participant regarding their educational experiences in the CBAP. In keeping with the Recursive Model I was an active participant in the research interview process.

Each interview started with some questions on a theme, a theme mostly derived from ideas gained deductively (Cresswell, 1997: 78) from information provided by previous interviewees, for example: “tell me about your experience today in the clinical environment”. The respondent was then asked to give their account of what was important to them and what a particular experience was like from their point of view (Bogdan and Bilkin, 1992). Participants were regularly asked to clarify points regarding what they believed to be important in relation to their educational experience. This made it possible to stay as close as possible to the research topic and in so doing to gain as much relevant and contextual information as possible (Fontana and Fry, 2000; Morse and Field, 1995). This task proved relatively easy on most occasions. Field notes were made during the
interview process and in some cases reflective notes were entered in the same notebook immediately afterwards.

The majority of semi-structured interviews were recorded and later transcribed in full. Informal interviews and conversations in the clinical setting were not recorded. However, participants were always advised whether the conversation was for the purpose of data collection or purely “small talk”. In which case, participants were advised that the conversation was not being noted. The number of times an individual participant was interviewed depended upon the theoretical relevance of the information provided (Glaser and Strauss, 1967).

Some of the final interviews were conducted by telephone immediately following completion of the program and these were recorded. This was mainly to double check for saturation of concepts and the telephone mode was adopted because of geographical distance.

Respondents varied in their willingness to provide information, for example, some were reluctant to lead the interview process and preferred instead to be asked a series of questions. This was useful too as intensive forms of interview generally permit in-depth exploration of responses (Charmaz, 2006). However, others were very forthcoming and willing to address new areas of concern and speak freely about their concerns and issues in many cases without the necessity for a direct line of questioning.

The four participants who were observed in the clinical environment and with whom I frequently engaged in informal conversation seemed much more relaxed and more willing to share their experiences, disappointments, and expectations than those participants who were merely involved in semi-structured interviews and not observed in the clinical environment. This could be associated with the
cross-cultural nature of the interview: an issue that will be discussed in more
detail in the next section. However, Denzin (1989) suggests that a good
interviewer is, by necessity, also participant observer to the extent that the
interviewer is participating in the life experiences of the respondent and is
observing the person’s report of his or her self during the conversation.
According to Denzin this helps the interviewer to acquire an in-depth working
knowledge of those they interview and I also found this to be the case.

Occasionally respondents would ask questions regarding aspects of the program
for example, “why can’t the program be longer or shorter” or solicit my opinion
on a range of clinical practice matters. My response to such queries varied
depending upon the question, and the context and value judgement regarding
the ethical implications of responding to the question or providing an opinion at
a given point in time. Published opinion is divided on the issue of how much the
researcher should or should not get involved in real conversations and in
providing opinions and/or answering questions. Fontana and Fry (2000) believe
that while the interviewer cannot be lifted out of the context, given that meanings
of questions and responses are contextually grounded and jointly constructed,
the scope of their function is to assess the respondents’ answers. This seems to
offer a more rigid and detached approached than that suggested by Guba and
Lincoln (1981) and Caulley (1994) and would in fact seem to limit the scope of the
inquirer as instrument with the capacity to respond to all personal and
environmental cues and the ability to interact with the situation to sense its
dimension and make them explicit (Caulley, 1994:5). Similarly, Adler and Adler
(1994) defend their stance on the practice of answering questions in the field and
letting their feelings be known, but they emphasise that the response to such
issues ought to be the subject of professional judgement and context at any given
time.
The work of O’Neill and Cullingford (2005) helped to add weight to the suspicion that students (NESB nurses in this case) can influence each other in terms of the tendency to shape each others opinions. The opportunity to collect data from two universities meant that not all participants were in contact with each other as neither cohort was aware of the involvement of the other. The same approach was utilised when data was collected from the teachers who were involved in the study.

3.2.5 Issues Associated with the Multicultural Nature of the Interview

According to Ryen (2003:337) the naturalistic challenges of cross-cultural interviews are usually presented as problems of communication. These problems, according to Ryen, can be associated with verbal and non-verbal forms of communication and in the main relate to issues associated with maintaining rapport between researcher and interviewees. As a means of addressing such possibilities Ryen suggests that the researcher needs to establish an atmosphere in which the respondent feels sufficiently safe to talk about their experiences and feelings.

This was particularly important in the case of this research because of the brief period of time available to collect quality data. In addition, the environment was foreign to the participants and to a certain extent to myself on the basis that although at that point in time, the setting was naturalistic in terms of how they were experiencing it, it was very new in terms of context and culture. Participants were also faced with the task of explaining what their standard of comparison was in relation to professional practice and ritualistic issues as they experienced them in the Australian context.

Ryen (2003) suggests that the naturalistic view is characterised by a belief that in principle at least, social reality is transparent in peoples’ words and actions, and
that the data are pre-produced, culturally stored, and independent of the interviewer-interviewee relationship. This may well be the case, but the mere fact that data is pre-produced and stored does not mean that the interviewee is in a state of preparedness to share it at all times, nor does it mean that interviewee and interviewer will attribute the same meaning to what is being reported. As mentioned previously there were differences in how participants wished to provide information in this study with some indicating that they favoured a more structured approach, whilst others adopted a more narrative style.

A further factor in this debate that serves to clarify the point made previously, is the suggestion that language has a filtering effect on perception, and concepts largely acquire their meanings through their being embedded in culturally specific explanatory verbal networks (Barnes, 1996:432). In other words, according to Barnes, different cultures provide different verbal interpretations of reality and of thought. In this regard however, Ryen rightly points out that rapport in cross-cultural contexts in particular is mediated by complex internal and external factors of day-to day involvement.

In the case of NESB nurses the unpredictable nature of the clinical environment created many challenges to their existing notions regarding the role of the nurse, professional identity, as well as concerns regarding assessment, competence and future professional employment and practice. I was conscious at all times that trust was the operative word in order to retain the confidence of the NESB nurses to share sensitive information with me.

3.2.6 Observation
Because grounded theory involves a sampling of human actions and interactions (Glaser and Strauss, 1967) and the human as instrument (Caulley, 1994), a period of time observing participants in the naturalistic setting had a number of
advantages as briefly mentioned in a previous section. Firstly, as posited by Descombe (1998) it provided an efficient means of collecting a substantial amount of data in a relatively short time; and, it provides a direct record of what people do, as interviews may not reflect their actual behaviour (Bodgewic, 1992).

According to Morse and Field (1995) the method focuses on the context and includes the reactions of individuals in the social setting and the structural-functional aspects of the society being studied. It also, according to Morse and Field (1995), enables the researcher to view the society objectively and in that way assists in validating and interpreting information provided by participants. Thus, in the case of this research, it provided an opportunity to compare and contrast what was observed with participants’ accounts of their actions and interactions with significant others in the clinical environment. It provided access to the “naturalistic” setting (Caulley, 1994).

A further advantage noted by Bodgewic (1992) and Caulley (1994) is that as time in the field passes the inhabitants are less likely to alter their behaviour due to the inquirer’s presence, thereby increasing one’s chances of observing the phenomenon as it actually occurs. In the case of this study it provided an opportunity to witness first hand the participants’ developing, and becoming conversant with, the professional language and culture of the nursing profession in Australia and the challenges associated with that process. Meanings were explored through ongoing verbal exchange between the participants and myself. This permitted the identification of the sequence and connectedness of events that contributed to the meaning (Bodgewic, 1992) of various aspects of the experiences that participants spoke about. Bodgewic (1992) suggests that the observation method is particularly suitable in situations where the situation of interest is obscured or completely hidden from the public and the inhabitants appear to have significantly different views than do outsiders.
To place this in the context of this research, hospital wards are relatively obscured from the public, particularly in the context of educational as distinct from clinical research. It was apparent both from interviews and observation that the respondents held views that seemed significantly different from those of the clinical staff in relation to their presence in the clinical environment, their clinical role, learning needs and expectations regarding their contextual knowledge base.

An important feature of this research is that, to an extent, both the participants and myself were not usual occupants in the clinical environment where the observation took place. The decision to observe participants in the clinical setting, therefore, was carefully considered for a number of reasons such as: the setting was not entirely naturalistic for the overseas-qualified nurses who had never previously been professionally employed in Australia; the degree of participation required, in the light of the fact that the research needed to be completed within a relatively short time frame because of the relatively short period over which the program is conducted (three to four months, depending on the university, with eight weeks clinical exposure); and issues associated with client confidentiality within health care settings, and the possibility that staff may view my presence as intrusive.

### 3.2.7 The Sample for Observation

Four participants were chosen who were deemed to be theoretically interesting. This decision was based either on interview data already collected from them individually, and in some cases complimented by demographic data that indicated a diverse range of clinical expertise, professional experience and cultural backgrounds. Importantly too, it was observed that these respondents were observant, reflective, and articulate, qualities that Bodgewic (1992) regards as an important consideration when selecting participants to be involved in the observation component of data collection. These considerations could also reduce
the likelihood of multiple respondents giving what Miles and Huberman (1994:278) describe as a “monolithic, party-line answer”, which can impact on the reliability and dependability of the data.

These participants became what Bodgewic (1992:57) refers to as “key informants” because in many instances they had access to observations denied to me as an observer, mainly because of the confidentiality issues in the health care environment and workplace dynamics mentioned earlier.

All four were assigned to the same hospital for their clinical experience. This enabled the author to maximise and vary observation times. It also served to enable me to become familiar with the physical environment (Bodgewic, 1992) and routines specific to individual clinical units, which in turn helped to choose the times of the day when I was most likely to gain maximum exposure to the participant of interest in order to observe their actions and interactions with clinical staff and occasionally with patients and with their clinical instructor.

The greatest advantage associated with the opportunity to observe participants in the natural setting was that with the repeated contact, albeit over a relatively short period of time, was that participants became familiar with my presence and behaved naturally. This addressed a very important facet of qualitative research in terms of making the inquiry more rigorous and trustworthy, as it reduces the risk of the Hawthorn Effect (Caulley, 1994).

3.2.8 Observation Techniques

Observation was carried out in an acute care clinical environment at different times of the day for four weeks (Edwards 1993:183; Lewis and Merideth, 1988:16). In addition, there were a series of conversations with the participants and their teacher each day at various points before, during, and after the observation.
These conversations were not taped but significant points were generally documented as soon a practicable following a conversation. A wealth of useful information was obtained from this informal interviewing in the field. Memos were written prior to leaving the venue following each observation session.

Detailed notes on each observation were written in the same journal that was used for notes during the interview processes. Recorded interviews were transcribed in full as were notes taken during and after observation and informal conversations, and all were analysed using the grounded theory method of open coding, axial coding and selective coding (Strauss and Corbin, 1990).

Association with hospital staff was limited. When it was possible I accompanied staff and respondents to the cafeteria. I was cognisant, however, that at times respondents may have had concerns regarding the fact that they would see me engaged in conversation with staff. Therefore repeated assurances were offered to the respondents that any information provided to me by them would be used for the purpose of my research only, and would not under any circumstances be revealed to a third party. This was viewed as one of the important external factors mentioned earlier that could have impacted on rapport with the participants if not managed in an open and transparent manner.

There was never reason to suspect that the respondents doubted my assurances. Rather, respondents at the venue where the observation component was carried out were at all times willing to provide information, and on many occasions approached me to offer information regarding their experiences. My conversations with staff were purely of a social nature and not for the purpose of data collection.
During the process of collecting data by observation at the clinical venue, I went to the hospital on alternative days. I visited at different times throughout the day including morning, late morning, lunchtime, change of shift times, as well as various time-slots during the afternoon shift. In adopting this approach it was possible to get a sense of the non-English speaking nurses involvement in the relevant teams, their ability to adjust to the dynamics of the workplace, their knowledge base in relation to a particular clinical speciality, the degree of strangeness they experienced in relation to work practices, routines, rituals, communication, and staff attitudes toward them.

**Journals**

According to Berg (2004) records that individuals keep are useful in terms of allowing the researcher to draw out the participant’s own definitions of the situation along with ways they make sense of their daily living. This view is also expressed by Morse and Field (1995), who suggest that the quality of data in diaries should not be influenced by recall since events are recorded close to the event being described. They do however require constant monitoring on the part of the researcher.

In the case of this research I usually inquired either before or following an interview with each participant how the process of maintaining the journal was going. I frequently got the impression that participants did not feel comfortable with this method of providing information, possibly due to competing pressures in the clinical learning environment and feelings of linguistic inadequacy. Although, when asked if they how they felt about the process they indicated that they were happy with it. There is a suggestion by Morse and Field (1995) that educational standard does have an impact on the level of cooperation of participants with the method. It is unlikely however, that educational level was a factor in the poor response rate in this case.
Each participant was asked to maintain a personal reflective journal for the duration of the clinical program. This did not prove to be a fruitful exercise as most participants did not return the journal despite much encouragement and coaxing, and those who did were extremely sparing in their comments except for one. Journaling did not seem to be a favoured activity on the part of the participants in this study.

Participants from both participating universities undertook the clinical component of the program at the same time, a factor that necessitated logistical gymnastics for me in terms of arranging interviews and observation sessions within a four-month time frame; and, with the added burden of geographical challenges in terms of distance to be travelled between the clinical venues where the participants were placed in order to conduct interviews and observation sessions.

3.2.9 Analytical Techniques
Glaser and Strauss (1967) advise that if an analyst wishes to generate theoretical ideas, new categories and their properties, hypotheses and interrelated hypotheses, as distinct from provisionally testing a hypotheses, then it is not appropriate to be confined to the practice of coding first and then analysing, since in generating theory it is necessary to constantly redesign and reintegrate theoretical notions as the material is reviewed.

When using grounded theory methodology then, data collection and analysis are inextricably linked (Glaser and Strauss, 1967). Data collection and analysis was an ongoing and comparative process with interviews taped, reviewed and in many cases transcribed prior to engaging in the next interview. Issues raised by the participants during the interview process were revisited during observation, in the case of those who were observed in the clinical environment.
In order to keep track of issues that interviewees cited as important to them, consideration was given to whether all respondents who spoke about a particular issue actually reported it as a negative or a positive experience. Participants were asked to explain each phenomenon in different ways and to explain what made the issue significant for them.

3.2.10 Data Organisation

In grounded theory method, data collection and analysis are an ongoing and inextricably linked process (Glaser and Strauss, 1967:101). Leedy (1997) points out that underlying all levels of coding is the constant comparative method of analysis defined as the continual process of comparing data segments and data codes within and across categories; a category being an abstract name for the meaning of similar topics and a pattern being the relationship between them. Leedy (1997:164) goes on to explain that because grounded theory is concerned with building theory, patterns and interactions among people are more interesting than individual perspectives per se, although he cites the view of Strauss and Corbin (1994: 280), that grounded theories connect this multiplicity of perspective with patterns and processes of action.

Qualitative analyses then do not follow a linear process, but rather as Leedy (1997) points out, it occurs in several cyclical and overlapping phases in which the researcher moves back and forth between different levels, which makes it a lengthy process. In fact Strauss and Corbin (1990:118) stress that the distinction between the stages of qualitative analysis is only for explanatory purposes.

The coding method suggested by Strauss and Corbin (1990) did offer an organising framework that provided good visual representation of the data. Data analysis in grounded theory then, is made up of three major types of coding which will be explained here. This process is not intended to replace the constant
comparative process but merely to serve as a process for checking that all data are accounted for (Strauss and Corbin, 1990).

**Open Coding**

According to Glaser and Strauss (1967:61) this is the first step in data analysis. It refers to the process of breaking down, examining, comparing, conceptualising and categorising data. All interviews and transcripts are analysed (Morse and Field, 1995).

In this case when transcribing the interview data a table was created with three columns. Each page was numbered. The question was typed in the left hand column, the response in the middle and sometimes comments on the right hand column regarding my view of the conceptual meaning of the response if that was apparent at the time of transcription. Following each response a three digit count on the tape was entered for ease of reference. It became clear that some of the initial concepts that were used to guide the process were of significance in helping the participants to provide information on the experience as they saw it. These responses were used to reframe the initial concepts and to create new categories and subcategories, for example questions about the learning experience on campus and in the clinical environment.

**Axial Coding**

This refers to a set of procedures where data are put back together in new ways by making connections between categories (Strauss and Corbin, 1990). At this stage in this research a coding matrix was created to facilitate the process of comparing experiences and assigning a category and relevant subcategories to those experiences. As the responses were entered on the matrix, the page number of the transcript was entered for ease of reference. Full quotes were used mostly, as it was believed that this kept me closer to the richness of the data and made it
easier to keep track of and link more obscure responses and negative case responses (Strauss and Corbin, 1990) that assigned significance to a category or subcategory.

A coding matrix was created (Miles and Huberman, 1994:241) for each of the three major themes and associated subcategories. The data that related to particular concepts was colour coded for ease of comparison and significance. For example, if a respondent spoke at length on a particular issue this became readily accessible for comparison because of density of text and colour.

As the study progressed and data collection, coding, and analysis revealed issues that were high on the agendas of the respondents I began to focus more clearly and intensely on those issues as they gained status as categories (Glaser and Strauss, 1967). Issues were broken up into a number of aspects of the same category; what Cresswell (1997) refers to as properties that provide the broad dimensions for the category.

Occasionally, properties of one category were linked with other emerging categories in order to enable the respondents to think about and articulate their concerns in the broadest possible terms. This facilitated a full explication of the major categories by ensuring that all information, regardless of how relevant or otherwise it seemed at the time of collection, was analysed or as Strauss and Corbin (1990) explain it, dimensionalised, in search of extreme possibilities for the properties.

Selecting Coding
Toward the end of the study a number of categories were collapsed into larger categories once I was satisfied that all dimensions of a category were considered in relation to that category and its overall significance in relation to the
development of theory. This process enabled the selection of the core category and to relate it to other categories by identifying relationships between them (Strauss and Corbin, 1990:116). Only information that was repeatedly found was included in the categories that were retained (Strauss and Corbin, 1990:187). The major category to emerge was “Moving Toward Contextual Competence” and all other themes and their properties related either directly or indirectly to this phenomenon.

3.2.11 Criteria for Quality in Qualitative Research as Applied to this Study

According to Guba and Lincoln (1989) the criteria for judging the quality of qualitative research parallel the criteria for judging quantitative research in the following way:

<table>
<thead>
<tr>
<th>Quantitative Research</th>
<th>Qualitative Research</th>
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</thead>
<tbody>
<tr>
<td>Internal Validity</td>
<td>Credibility</td>
</tr>
<tr>
<td>External Validity</td>
<td>Transferability</td>
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<tr>
<td>Reliability</td>
<td>Dependability</td>
</tr>
<tr>
<td>Objectivity</td>
<td>Confirmability</td>
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The criteria for judging qualitative research then are explained as follows:

**Credibility**

Credibility is maintained through *prolonged engagement* with the participants over the entire period of their enrolment, and repeated contact through the interview process with those participants who were deemed to be theoretically most interesting. In this case I spent significant periods of time observing and interviewing the participants over the entire duration of the program as I have explained in detail in a previous section.
Persistent observation: As explained earlier there was persistent observation of those participants who were chosen to be observed in the clinical environment. I observed on alternate days for four weeks at various times each day. I was available to provide information or answer questions regarding the research process at all times. All participants were provided with my contact details (telephone number and email address).

Peer Debriefing: My supervisor proved to be a valuable resource in this regard in terms of not having a nursing background and posing questions that encouraged me to examine my own assumptions and judgements in relation to the research process.

Negative Case Analysis: There were a significant number of cases who fitted a particular category and there were some who reported quite different experiences. This according to Guba and Lincoln (1989) provides confidence in a hypothesis that is being proposed.

Progressive subjectivity: The process of change was documented throughout the study through consultation with my supervisor with ongoing questions and challenging propositions regarding my beliefs and interpretation of my findings.

Member Checks: The main points of the interview were summarised at the end of each session and participants were asked if the points made were an accurate reflection of what they believed they had said. Participants were also asked at this point if there were any further issues that they would like to speak about, in particular in relation to issues that had not been raised during the interview process.

Triangulation: Miles and Huberman (1994:267) suggest that triangulation is supposed to support a finding by showing that independent measures of it, agree with it, or at least do not contradict it. The aim according to these authors is to pick up different biases and strengths so that they can compliment each other. They suggest the following means of triangulating: data source, which can include persons, times and places; and method, including observation and
interview. In the case of this project data were collected through different sources and different methods (Mertens, 1998), that is; through interview, observation and journal notes.

Different sources: An Australian born nurse who undertook the same program to enable her to update her skills following an extended period of absence from professional practice was interviewed. This person was interviewed for the purpose of “Discriminant Case” analysis (Cresswell, 1997). The nurse was interviewed late in the project, and according to Strauss and Corbin (1990:187) this enables the researcher to verify the story line. The nurse who was interviewed for this purpose underwent the clinical component of her education at a different clinical venue than that where observation was carried out, but shared the clinical venue with the group of NESB participants who were interviewed but not observed during this study.

The second method used consisted of in-depth interviews with three teaching staff involved with the CBAP. Two of these teachers had worked closely with the NESB nurses in the clinical environment providing clinical instruction, supervision, and competency assessment. One was also involved with the theoretical and simulation component of the program. The latter person had previously worked as a clinical supervisor and was therefore ideally situated to provide multiple perspectives on phenomenon. Two clinical teachers were interviewed immediately following completion of the respective courses, one teacher from each university. I interviewed the third teacher who had a more diverse range of educational involvement with the nurses. This interview took place six months after the interviews with the NESB nurses and approximately five months after the interviews with the clinical instructors. One of the teachers mentioned above was involved with the direct supervision of the nurses who were observed in the clinical environment, and two teachers were involved with the education of those who were not observed, but who were interviewed and
provided with an opportunity to talk about all aspects of their educational experience. None of the teachers were aware of the identity of other teachers who were interviewed. This served two purposes; firstly, anonymity and confidentiality and secondly, it ruled out the likelihood of collaboration and the provision of answers that could reflect a sense of group loyalty rather than a more individualised account of the experience.

**Transferability**

Careful description has been provided regarding the context in terms of the time, place, setting, and detail of the selection process and how data collection and analysis was carried out and documentation processes maintained throughout the project. This is referred to by Mertens (1998:183) as thick description. This and the fact that the study occurred in a natural setting (Caulley, 1994) could enable someone interested in making a transfer to decide whether a transfer can be contemplated as a possibility in another setting or situation (Lincoln and Guba, 1985).

The original stimulus to undertake the research was related to my own professional experience of the difficulties experienced by NESB nurses and the findings of Hawthorn (2001) and others that they experienced difficulties with adaptation because of organisational and interpersonal reasons. On this basis there is some suggestion that the conclusions from this research would have transferability in general terms. However there is not a lot of research literature that relates specifically to NESB nurses enrolled in CBAP.

The main purpose of this kind of research then, is mapping, that is, to integrate new knowledge with existing knowledge. It will be an accumulation of repeated studies that will strengthen estimates regarding transferability, as viewed by researcher and practitioners in the field.
Dependability

According to Miles and Huberman (1994) the underlying issue is whether the process of the study is consistent, reasonably stable over time, and across methods. Some authors make little distinction between dependability and confirmability (Caulley, 1994; Miles and Huberman, 1994:278; Morse and Field, 1995) and actually group reliability and auditability. In this project the procedures for data collection and analysis were made explicit throughout, as explained previously, and all interview transcripts, tapes (cross referenced with transcripts), field notes and maps are available for inspection. Tape recordings, transcripts, field notes, memos, and site maps have been retained and are available to be accessed should an audit trail be called for.

Confirmability

According to Mertens (1994) it is important that qualitative data can be tracked to its source. As indicated above, interview transcripts, taped records of interviews and notes made in the field during observation and informal conversations with participants, as well as site maps and dates and times of events, are on record. Direct reference is made to these sources in the data chapters by means of, for example, the position of a particular statement on a tape or the page and line of the transcript.

3.2.12 Limitations

The study was conducted in two universities based in the state of Victoria. Potential users of findings would need to examine the recommendations for fit in similar situations (Lincoln and Guba, 1995). The data were collected through interview, direct observation, and the use of personal journals maintained by thirteen non-English speaking nurses. For the purpose of triangulation, data was also collected from three teachers through in-depth interviews. An English speaking, locally trained nurse was also interviewed. This nurse undertook the
program in order to regain registration following a period of not practising. Although the data were comprehensively triangulated it was confined to NESB nurses, their teachers, and a “Discriminant Case” and did not include the opinions of hospital-based nurses at participating clinical venues.

Data collection in the clinical environment was frequently hampered by difficulty in locating a particular participant at any one time, with limitations placed on my access during intimate nursing and medical procedures, and the exigencies of daily practice as experienced by the participants. These conditions arise from the dynamic and rapidly changing nature of the clinical environment in the acute care settings. As well, issues associated with privacy and confidentiality, and the various agendas of staff and participants in the clinical care environment were important. The implications of this for the research were that interactions between participants and ward nurses were obscured and this created a heavy reliance on interview data during those times when access for the purpose of observation was limited. However, in most instances the observation process did provide an additional source of data collection.

A unique feature of this research is that both the participants and myself were outsiders in the clinical environment in which the observation took place. However, the setting was conversely naturalistic for the NESB nurses during that period of time because of the necessity for them to partake in the clinical component of the CBAP.

Outwardly, for the most part, my presence did not seem to concern staff, in fact, most did not inquire regarding my presence or my role in the clinical environment. Most times I would have preferred if staff members did make such enquiries, as it would have provided an opportunity to clarify my intent and perhaps to enhance my relationship with staff and therefore accessibility to the
NESB nurses that I wished to observe at a given time. On the other hand however, the distance as it existed probably strengthened the author’s objectivity.

Participants from both participating universities undertook the clinical component of the program at the same time, and as previously noted this necessitated logistical gymnastics in terms of arranging interviews and observation sessions within a four-month time frame. This was complicated by geographical challenges in terms of distance to be travelled between the clinical venues where the participants were placed in order to conduct interviews and observation sessions.

3.3 SUMMARY

As I have indicated in chapter 3 p56 that the approach to the use of the grounded theory method in this study leant more toward the Strauss and Corbin (1990, 1998) inflection with the emphasis on the interpretative constructivist paradigm than that of the classical Glaserian version of the method (Glaser 1992). For example, the literature was reviewed prior to commencing data collection to locate the study in the current landscape in relation to the global movement of nurses, the current global shortage of registered nurses and to gain a perspective on issues previously discovered in related works. The work focused on perceptions of the NESB nurses regarding their educational experiences whilst enrolled in CBAP and for that reason had a significant focus on the “what” question and social processes which, although significant, were not the entire focus of the analysis.

The evolution of grounded theory has been traced from its beginnings in the 1960s. In addition, the ongoing debate in relation to grounded theory has been acknowledged. In that regard I share the views of Eaves (2001) that debate in relation to this method, like other forms of scholarly debate, creates discourse
and in turn discourse creates knowledge. It is argued that the value of the method used in this study is evident from the rich description provided by respondents, and the value of the constant comparative method is evident in being able to lead to the development of a model that has the potential to be useful in relation to the future education of NESB nurses, as well as skill recognition and utilisation amongst that group.

It is possible that the reading of, and utilisation of, the grounded theory method in this research may be subject to criticism. However, the author believes that the method was utilised in keeping with the cannons of quality qualitative research and in keeping with the guiding principles of the interpretative constructivist paradigm, and to that extent the method provided a worthwhile set of assumptions as well as methods and techniques to investigate the chosen topic with its associated complexities.
CHAPTER 4

TEACHING AND LEARNING

Theoretical Learning Context
4.1 INTRODUCTION

This chapter and the chapters to follow will present the results of the analysis of data collected during the course of this study. The main focus here is on the educational experiences of the NESB nurse.

The results will be presented in accordance with the themes that reflect the learning experiences of the nurses during the period of enrolment in the CBAP. The responses relevant to the theoretical component will be presented in this chapter and those relevant to the clinical education environment in the next chapter.

All participants are provided with a pseudonym. The participants’ responses will be italicised and a pseudonym plus the page and line number of the transcript will be in bold size ten-font immediately after the quote. A typical example of a quote would be:

*In theory if they work with a preceptor they should work the same shifts, but in reality they don’t.* Laura, PG5: Ln2

Discussion within each section will provide an opportunity to explain, contrast, and synthesise the various perspectives of the non-English speaking nurses, their teachers, and an Australian born English speaking nurse (“Discriminant Case”) in relation to emergent themes, and to explicate the findings in relation to existing theoretical perspectives regarding those themes.

The constant comparative method has revealed a core category. This was derived from the accounts provided by the participants regarding their motives for doing the program and their learning experiences throughout. According to Strauss and Corbin (1990:120-121) the core category is abstract enough to encompass all that has been described in the story: a central
phenomenon. That category in this case is: *Moving Towards Contextual Competence* and three interrelated themes: *Teaching and Learning, Adaptation, and Experiencing Diversity*. Each major theme is supported by a number of smaller categories, explained by Cresswell (1997) as properties that provide the broad dimensions for the category this is to facilitate explanation and clarity of results.

The results will be presented to reflect “multiple realities” and will therefore in some instances show a diverse range of perspectives on the same phenomena. These variations will be reflected in the presentation of the results in order to delineate consistencies and inconsistencies between reported experiences and exploration of the meaning of those experiences in terms of teaching, learning, and the process of adaptation and coping with diversity during the transition to practice in the Australian context.

### 4.1.1 Theoretical Learning Context

The theoretical component of the CABP takes place at the university campus. Theory of nursing refers to what Benner (1996) refers to as medical and nursing knowledge and draws primarily upon the sciences of chemistry and biology. According to Benner (1996:29), typical rules of thumb for the application of this knowledge are that if you observe a particular phenomenon then a specific course of action should be taken.

This view of nursing, however, could be regarded as overly simplistic in the light of the current discourse on the role of the registered nurse (Conway and McMillan, 2006; NBV, 2006; NRNE, 2002). The role of the nurse is mainly depicted as being of a dynamic nature requiring an extensive range of skills and knowledge, being intellectually demanding, and requiring increased understanding of various industrial, fiscal, legal and ethical ramifications of
practice. In preparation for the stated rigors of practice, non-English speaking nurses are provided with an introduction to the Australian Health Care system (AHCS) and the subjects of law and ethics, pharmacology, and acute care nursing as they apply to the practice of nursing in Australia.

The initial contact time on campus varies between providers, but is generally in the range of two to six weeks with the number of contact hours per day varying depending on the number of days the nurses are required to attend on-campus education and training. The structure of the program varies slightly from one university to another (Wickett and McCutcheon, 2002; ANMC, 2004), but the content is similar as the curriculum is externally regulated by the NBV and is competency based.

4.1.2 Analysis and Results
The core category that emerged from the NESB nurses’ narrative accounts of the perceptions of their learning experiences was derived from a sense that they all shared a common goal: Moving toward contextual competence in Victoria. In advancing this objective the following themes emerged strongly from the data.

These themes are shown in Figure 1 and will each be discussed in a separate chapter as follows:

1. Teaching and Learning and the cultural, linguistic, and professional issues associated with learning in the classroom and in the more complex and challenging clinical environment are discussed in Chapters 4 and 5.

2. Adaptation. This theme will explain the nurses’ perspectives on how they coped with the experience and retained the determination to persist with the program despite the impact of cultural,
linguistic, intra-personal, and interpersonal processes and experiences (Chapter 6).

3. *Experiencing Diversity.* This theme reflects the challenges experienced by the NESB nurses in relation to working with culturally diverse groups of both staff and patients (Chapter 7).

**Figure 1. Moving Towards Contextual Competence.** This figure shows the three main themes that emerged from the core category, that is, Moving Toward Contextual Competence in Victoria. The themes will be further developed in Figures 2, 3 and 4.

**4.2 Teaching and Learning: Theoretical Learning Context**

Exploring the perceptions of non-English speaking nurses of their educational experiences whilst enrolled in a CBAP necessitated a focus on learning in two distinct but interrelated environments: on campus, and in the clinical environment. This chapter will focus on the experiences of NESB nurses on campus.

There is an increasing belief that nurse education should remain within the tertiary education system. It is suggested in the *Submission to the Review of*
Higher Education: Financing Policy (NBV, 2006) that universities must continue to play an important role in the preparation of graduates, including nurses, to be effective professionals in industry. This findings of this research then is likely to be of interest to nursing departments within the tertiary sector that provide CBAP for NESB nurses.

Non-English speaking nurses who are enrolled in the CBAP hold a diverse range of professional, educational, and cultural backgrounds and therefore many of them encounter varying degrees of discomfort as they approach learning in a challenging dual sector arrangement. In enrolling in a university based CBAP the overseas nurse takes on a dual role and identity; that of overseas student and migrant nurse.

It became clear early in the data collection process that participants were eager to talk about their experience of returning to the classroom. For many, this was to be their first experience with the tertiary education sector as most received previous professional education in a hospital-based system. But more importantly, many had not undertaken formal study for a considerable period of time.

Data from the early stages of the study revealed that the NESB nurses fell into three groups in terms of their previous professional experience regardless of their country of origin. These were:

- Specialists
- Experienced generalists
- Inexperienced generalists

Those who fitted the specialist group were nurses who had practised in particular clinical specialities such as operating rooms and intensive care units for an extended period, for example, eight to ten years. The group who
were classified as *experienced generalist* on the other hand were nurses who had practiced in a variety of acute care settings, for example medical-surgical units, and some nurses who fitted this description had also worked in specialised areas such as accident and emergency. In addition, they had diverse experience outside of their countries of origin. An Indian nurse for example had worked for extended periods in acute and community care settings in Saudi Arabia. The inexperienced generalists were nurses who had graduated in the previous three years and had experience in one or two clinical areas such as coronary care and surgical units.

Recognising this differential in experience created an opportunity to compare and contrast the perceptions of the participants and to observe if there were differences in their perceptions of their learning and socialisation experiences based upon their level of professional experience and existing clinical expertise. Firstly, however, their experiences as international students on campus will be discussed.

**International Students**

Dissatisfaction relating to a range of matters in the educational environment is not uncommon for overseas students (in this case NESB nurses) according to O’Neill and Cullingford (2005), as they face complex challenges associated with unfamiliar approaches to education. Many are accustomed to didactic approaches to teaching versus the more independent problem solving approach (Davidhizar and Shearer, 2005) utilised in the tertiary system in Australia. These researchers concluded that improvement and modification is needed in teaching strategies to accommodate culturally diverse student populations in nursing courses. Meanwhile, O’Neill and Cullingford (2005:110) point out that traditional methods of research that are mainly based on attitudinal surveys in many cases fail to provide substantial detail
regarding the experiences that give rise to students, attitudes. The views seem to represent a key point in favour of a more detailed study in order to gain qualitative accounts of the experiences of international students generally, and NESB nurses in particular.

The constant comparative method of data collection and analysis provided an opportunity to engage in continuous close contact with the participants throughout the study, utilising in-depth interviews and observation which in turn yielded detailed description of the issues that challenged the participants in relation to their learning experiences. The method also enabled the participants to talk about what they perceived to be the positive aspects of the program.

Opinions regarding the NESB nurses’ experiences in the classroom centred mainly around four factors: the experience of sitting in the classroom from nine to five; unfamiliar concepts such as law, ethics, and the Australian Health Care system; pharmacology; and the duration of lectures. The duration of lectures was viewed as problematic particularly where lectures were up to three hours in duration as this was reported as having an impact on the nurses’ ability to grasp concepts.

The experience of sitting in the classroom from nine to five was also reported as a difficult and unfamiliar process for some participants as the following comments suggests:

> We have lectures for two hours, but we are not used to that in...forty-five minutes to one hour then break. Feel sleepy because early morning we are getting up and coming to university. **Louise, PG1:Ln2**
Some continuous lectures very difficult. We would have three-hour continuous lecture, usually in our place we would have one-hour lecture then a break. Jane, PG:Ln3

It’s very hard to study from nine to five or six. Alana, PG4:Ln1.

However, not all participants found the lecture time excessive:

I have long time lecture in China so I don’t think it’s too long.

Lee Lin, PG1:Ln10

These comments about the duration of lectures represented the least concern. The responses provided in relation to the NESB nurses’ perception of their experiences in the classroom varied depending upon the stage they had reached in the course at the time the interviews were conducted.

4.2.1 Unfamiliar Concepts

The subjects that caused most concern for participants were the Australian Health Care system, Law and Ethics, and Pharmacology. Although nurses reported familiarity with the administration of medications in their countries of origin, most reported significant anxiety regarding their theoretical knowledge on the subject and the administration of medications in the Australian context.

Firstly to the issues of Law and Ethics. According to Walsh (2002:13), the moral premise of nursing practice is founded in the nurse-patient encounter, which is embodied in the concept of caring. The practice of nursing according to Johnstone (1999) never occurs in a moral vacuum, nor is it ever free of moral risk. In Australia this relationship is guided by the Code of Ethics for Nurses and Midwives [2000] and the Code of Professional Conduct for Nurses and
Midwives [2000] (ANMC, 2004). Nurses, by the very nature of their work, come in contact with, and deliver care to, a potentially vulnerable clientele. According to Johnstone (1999:3), there is an associated expectation of special obligation on the part of nurses to reduce this vulnerability by conforming to particularly high professional standards in their professional and non-professional lives.

The law subject gave rise to varying degrees of concern for participants. Out of the thirteen people interviewed, three expressed serious concerns, three a moderate concern, and five a minor issue. The remainder did not comment.

The following comments are typical of the concerns expressed in relation to the content and the NESB nurses’ ability to grasp the concepts of the subject:

We are not getting all the area, when I go to the hospital I am also worried to[sic] do some of the things because I’m worried about how it will affect me in the future, so a lot of confusion is there because I’m not getting enough knowledge about legal system. Nanette, PG1:Ln6

Nanette was a nurse of Indian origin who had approximately three years post graduate experience. Her concern regarding the subject of law was mainly associated with grasping the concepts. A similar concern was expressed by Mei Li who was a specialist operating room nurse for eight years:

In China if let [sic] me read law book in Chinese sometimes we don’t understand because we are not studying law and if in Australia you know, we read it in English more difficult. So we have to take lot of time to find out about the answer, you know we don’t have lots of time. Mei Li, PG 3:Ln2
In the light of these comments it seems that some nurses believe that they are not receiving sufficient theoretical coverage of the law and ethics subjects and that there is not sufficient strength in the connection of those subjects to the clinical practice domain. It also seems that there is a need for greater variation in the teaching strategies utilised in the classroom and an expansion of content as indicated by this comment from Lei who was a specialist nurse in the area of paediatrics:

*It’s important to learn about the law they need to give us more examples, only three lectures and very quickly and they give us lots of notes and questions and they use special terminology and its too difficult for us to understand. We have the lecture with the local students and they could help, but it’s better to give examples, because when I was in China I got my Bachelors in Chinese law so I’m so concerned about it.* Lei, P11:Ln 2-3

In contrast the Australian nurse (“Discriminant case”) indicated that the subject was not problematic:

*OK, but it was revision* Susan (“Discriminant Case”), PG1:Ln5

It seems to be a reasonable expectation, in terms of helping NESB nurses to integrate theory and practice, that they be provided with examples and explanations of legal terms in order to enable them to contextualise the knowledge. It is suggested by Conway and McMillan (2006) that if clinical and classroom learning are viewed as separate entities then there is a risk that students will perceive an insurmountable division between the theoretical and practical aspects of nursing. And, although Conway and McMillan seem to refer to undergraduate student nurses in this context, it is suggested here that the issue is no less significant for non-English speaking nurses as this
kind of knowledge impacts on the political framework for clinical practice in Australia.

However, one teacher pointed out that students do not necessarily notice the connection between the two educational settings: on campus, and the clinical venue, as this statement would seem to suggest:

Students (NESB nurses) can go through the day getting great experience with law, with drug administration and informed consent [both with legal implications] but they won’t actually see that as experience…for the exam. Gail (Teacher), PG8:Ln5

Some of the issues experienced by the non-English speaking nurses may be associated with language or a failure to make strong connections between theory and practice and therefore between different modes of teaching. Such a technique that, according to Rutherford-Dijkhuizen (1995), is imperative when teaching NESB nurses. It is also suggested by Rutherford-Dijkhuizen (1995), however, that NESB nurses require a lot of re-enforcement. In the next paragraph the NESB nurses’ concerns regarding the Australian Health Care system will be explored.

The Australian Health Care System (AHCS)

All NESB nurses commented on this subject. One participant believed that there was not a great deal of difference in relation to how she perceived her professional responsibilities to the patients she cared for in Australia compared to how her duty was discharged in China. Nevertheless, all expressed concern that the system was different and that it caused some anxiety for them in terms of learning the concepts and applying knowledge
and skill in the clinical environment. The following comments are typical of the responses from NESB nurses:

*As a nurse I think most principles are the same around the world, for the nurse, not exactly the same.* Lee Lin, PG2:Ln9.

Most NESB nurses stated that the AHCS was a very important subject in the development of their knowledge to work in Australia and some regarded the subject as being one of the best things about doing the course:

*The good things through this course we can learn about the Australian Health Care system.* Lei, PG1:Ln 1

*Before coming to class I don’t know anything about the Australian Health Care system. So from the classes and examination I gained understanding. It wasn’t much [sic] difficult.* Jane, PG1:Ln6 & 8

The next comment relates to concerns regarding the mode of teaching the subject on campus:

*If there is the Australian Health Care system if they say the policies are 1,2,3 we won’t remember that if they take one procedure and explain that then it will be easy for us.* Angeline, PG1:Ln7

*It’s that also the Australian Health Care system. So different from…In the hospital here we have so many policies that we don’t have in India for example discharge of patient, home visits get organised. In India the relatives look after them, nurses only give medications and all that.* Louise, PG1:Ln8
Pharmacology

As with other aspects of the nurses’ education, concerns regarding knowledge of pharmacology were related by the participants to the two learning contexts, the classroom and the clinical environment. The focus for concern with the classroom component was inadequate lecture time for the pharmacology subject and inadequate preparation time prior to the examination. The issues in relation to this subject reported in the clinical learning environment were broader in range and will be dealt in detail later in Chapter 5. Eleven out of fourteen participants expressed concerns regarding pharmacology in relation to both the theoretical preparation and practical issues. However, some related the issues to the clinical practice rather than the theoretical component. Therefore some typical accounts have been reported here as well as in the ‘Clinical Learning Component’ in Chapter 5.

Responses focused mainly on the differences between the system with which they were familiar and the Australian context. Participants also commented on what they perceived as the inadequate coverage of the topic on campus:

*The university preparation for practice was good, but it could have been better e.g. more on medications, we only had one hour.* Deanne, PG7:Ln1-2.

*Pharmacology difficult. Time is limited the lecturers do not have enough time to explain all the drugs for us they give some notes. Then we read it through by ourselves.* Lei, PG3:Ln5-6

*The drugs are different from our country some are similar; actions and side effects.* Evelyn, PG1:Ln8
Pharmacology they use generic names and where I practice they use trade name and each drug like that and so very difficult.

Angeline, PG2:Ln3

The Australian nurse (“Discriminant Case”) also reported some difficulties with pharmacology in response to a question on whether there were any subjects in particular that she found more difficult than others:

Nursing side of it revising learning new thing, pharmacology and calculations, learning new drugs, incorporated into nursing, nursing is the most difficult. Susan (“Discriminant Case”), PG1:Ln3

This claim that nursing was the most difficult subject was in contrast to the overseas nurses who reported experiencing more difficulty with subjects such as the AHCS and law and ethics, and pharmacology. This could be related to the fact that most NESB nurses, with the exception of one, had up to date clinical experience prior to commencing the program. In relation to the pharmacology subject there were no significant differences in the concerns expressed by inexperienced generalists, experienced generalists and specialist nurses.

4.2.2 Course Structure and Duration

Opinions varied regarding the structure and duration of the CBAP. Eight out of fourteen believed that it was not long enough. Two thought it was too long and two thought it was just long enough. Hailey, an experienced unit manager in her previous position in India, said:

It should be five or six months. Hailey, PG1:Ln10
I think that clinical practice should be longer because I don’t think two months is enough. It’s enough to familiar [sic] with, not enough to learn. Lei, PG1:Ln2

Deanne an experienced generalist nurse seemed to have mixed feelings about the duration of the program:

The good thing is that it’s short, but that is also bad, it’s too congested and I don’t think we get enough experience in clinical practice, then, we still have to study for exams all the medications. Difficult to study and work no study time for exam. I think clinical should be four months instead of two…We were at university for month [sic] and a half and we went to practical for another month and at that time we have to prepare ourselves for exam. We should have three or four days to prepare ourselves for exam and then to go [sic] to practical. Deanne, PG1:Ln2

An experienced generalist nurse from the Philippines had this to say:

I think it’s long enough for orientation to make us informed of Australian way of managing patient, Australian nursing, but to learn it’s short I think very short Leesa, PG3:L11

Mei Li, a Chinese nurse who had specialised in theatre nursing for a number of years, believed that the program should be much longer and that nurses who had specialised previously should be provided for in a way that is more in keeping with their level of expertise:

The educator said the NBV only give us three months for the pre registration course, but I want to know why they only set the three months not the half year. Mei Li, PG18:Ln7
For general nurse maybe its enough, but for specialist nurse they will need some special area. Mei Li, PG19:Ln10

I just talked to some colleagues, some say three months is enough, for me maybe a bit longer maybe four or five months, give us some time we study some things [sic] Mei Li, PG19:Ln

Two people believed that the course was too long; Nanette was an inexperienced generalist:

It’s enough. I think it’s a little bit long. When we go to one hospital and work there we will learn all these things in two to three weeks. Nanette, PG4:Ln

I asked Jane, an experienced generalist with nursing experience in India and Saudi Arabia, if she believed the course prepared her for practice in Australia:

In my opinion because we are already registered nurses in our country this three months is long period. Two months enough. Jane, PG2:Ln9-10

Some participants expressed concerns regarding the structure of the program in terms of the preparation time available for examinations:

I think it’s better to finish the exam before we go to clinical practice when you have clinical practice you are tired you are anxious you are stressed so you have to learn at clinical, when you go home you have to learn some medications because on the ward you only have time to know what this medication is for what, but you don’t know the dosage…when you go home you have to read some books also diseases…because between the practice you have the exam. Mei Li, PG16:Ln2
I asked Gail, a teacher, to speak with me about the mix of time the NESB nurses spend at the university and the fact that they come to clinical practice for one month and then go back for examinations:

Ya, the exam is quite hard in the middle of it because the focus is just on the exam and they are tired students, the way I get around that is just having debriefing sessions e.g. if I know they have to revise head injury I’ll make sure someone is looking after as stroke patient and talk that through so in general we are going over the same theories… and they can use clinicals for study as well and they appreciate that. Gail (Teacher), PG8:Ln5

4.3 Summary
The information that was offered by the NESB nurses in relation to these issues seem to suggest that considerable dissatisfaction exists in terms of the duration and structure of the program. In particular, unfamiliar concepts gave rise to considerable concern in relation to how the NESB nurses perceived their ability to grasp the relevant concepts in these subjects. Importantly there were concerns expressed regarding their ability to apply the relevant principles in clinical practice.
CHAPTER 5

TEACHING AND LEARNING

Clinical Learning Context
5.1 The Clinical Learning Context

The value of clinical education cannot be overlooked in the preparation of health professionals (Alexander, 1995; Benner, 1996; Conway and McMillan, 2006; Edmond, 2001; Foucault, 1994; Johnston and Preston, 2001; May and Veitch, 1998; Napthine, 1996; NBV 2006; Williams, 2000). In the case of nurse education it provides what Billett (2001) and Chan (2001) refer to as learning experiences that are authentic and contextual, and also plays a key role in the preparation of nurses for clinical practice (Chan, 2001; Clare et al., 2003; Johnston and Preston 2001). According to Napthine (1996) it completes the education begun in the classroom. It is however, suggested by Conway (1996) as cited in Williams (2000:15), that the importance of organisational culture cannot be ignored in promoting or hindering the acquisition of various types of nursing knowledge in the clinical environment.

The clinical education component of the CBAP takes place at a hospital. The clinical placement is organised by the university as part of the overall structure of the program. Participants are for the most part not provided with a choice of clinical venue, with places limited and subject to availability at any given time. As a direct result of this, it is not uncommon for participants to be required to move from one clinical venue to another in order to complete the mandatory clinical education that is the practice component of the program.

The clinical teacher model of clinical education was utilised in both participating universities. The clinical teacher model means that an educator is employed by the university and deployed to the clinical venue with responsibility of supervising the clinical learning and assessment of up to eight students at a given time (Clare et al. 2003). In contrast to classroom teaching, clinical education takes place in a complex social context where a
teacher monitors the needs of both clients, students, and clinicians in order to ensure optimal learning opportunities.

For this study some participants were interviewed in the first week of the clinical component while others were approximately one month into the clinical placement. Some were interviewed more than once and at various stages during the program as well as shortly after completion. The reason for the variation was mainly related to two factors: theoretical sampling (Strauss and Corbin, 1990) and also availability of the participants. It is important to remember that because of the open-ended nature of the questions, the responses for the most part seemed to reflect the issues that concerned people most on the day the interview took place.

It is generally accepted that the majority of learning takes place in practice (Edmond, 2001) and although it involves a professional and therapeutic relationship (Walsh, 2002), much of the knowledge embedded in clinical nursing is procedural, operational and contextual, (Benner, 1996; Chan, 2001; Williams, 2000) with objectivity and efficiency being the central value (Bjornsdottir, 1998; Jones and Cheek, 2003; Mayben, 2006). The implications for NESB nurses is that despite their motivation and readiness for change difficulty coping with the complexity of new environment may lead to feelings of inadequacy and despair (D’Netto, 2000).

5.1.1 Perspectives on the Clinical Learning Environment

Bjornsdottir (1998) conducted an ethnographic study in two hospitals in Iceland and her observations regarding the characteristics of nurses’ work bears many parallels to the work of nurses in Australia
In commenting on her own observations, Bjornsdottir admits to being struck by the magnitude and complexity of the work to be carried out on a shift, as well as the information to be remembered and acted upon, the routine tasks, and the amount of care to be provided. She described this as being almost beyond comprehension. The work, according to Bjornsdottir, had a certain rhythm; a fast pace to it, with everyone trying to keep up. At the same time she observed that the work of the registered nurse was constantly interrupted by phone calls or visits to the units by physicians, physiotherapists, social workers, and occupational therapists to mention but a few from her list. A considerable amount of the nurses’ time, she observed, was actually spent ensuring the smooth running of the system, which involved monitoring laboratory reports, medical treatments, alerting physicians to laboratory results, and suggesting changes in treatment regimes (Bjornsdottir, 1998:353).

Similarly, Mayben et al. (2006) noted that speed has historically been associated with nurses’ work and that the “good nurse” is a quick nurse. This view can create unnecessary pressure for the learner in the clinical environment if the pressure to perform outweighs the learning needs of the individual.

A similar study was conducted in Australia by (Jones and Cheek, 2003) and in the United Kingdom by (Mayben et al. 2006). Nurses involved in the Jones and Cheek (2003) study in Australia provided similar accounts, to those found by Bjornsdottir. For example, they described the pace of their day as fast, or having too much to do in too little time. All experienced staff shortages and saw them as a challenge to being able to provide the level of service that they would like to and, in addition, felt this lead to a high risk of error and low morale. Mayben et al. (2006), suggested that the pressures came from a number of sources including limited staffing, poor skill mix, and high patient turnover. The findings of these three studies provide an ideal narrative to
provide an insight into the characteristics of nurses’ work in the clinical environments where NESB nurses undertake their mandatory clinical education. It also helps to show how the pace, volume and complexity, and uncertainty of the work, compounded by staff shortages, (Edmond 2001; Mayben et al.. 2006) help shape the clinical unit as a learning space for better or worse.

In the case of the NESB nurses the clinical learning environment provides their first encounter with the delivery of care in the Australian Health Care system. This brings them face to face with the cultural, linguistic, social, legal, and ethical realities of daily practice in what is for them an alien system. Clinical education is conducted in a space that is aptly described in (NRNE 2002: Discussion Paper: 2) as:

Occurring at the intersection between health care and education settings. It is defined as a highly complex space occupied by numerous health professionals and professional bodies, it involves government and non-government employer agencies; and involves multiple levels of authority and regulatory regimes and frameworks.

All of these factors contribute to the burden of adjustment for the NESB nurse (Cowin and Jacobsson, 2003). According to Edmond (2001), learning to interact with and manage the clinical context in all its complexity is a major factor in nursing practice.

It is also suggested here that the acquisition of skill on the part of the non-English speaking nurse is not hastened by what Barnum (cited in Benner, 1996: viii) refers to as our “professional stance with regard to the level of skill
and knowledge that we expect from a graduate of an accredited school”. Here, Barnum points out that it is often assumed “that a graduate of a particular school is somehow a finished product, that he or she is ready to perform as a nurse”.

In the case of the participants in this study, there was broad variation in the level of previous clinical experience in terms of years of practice, area of practice, as well as cultural and linguistic backgrounds. Some nurses who believed that they practised at expert level in their country of origin expressed significant concerns regarding their beginning level of practice in the Australian context.

There were several factors that emerged from the data analysis regarding what the nurses reported as having a significant impact on their learning experiences in the clinical environment. The most significant of these was the actions and interactions of other staff as perceived by the non-English speaking nurses. It is suggested by Apker et al. (2006) that despite the fact that communication principles are regarded as an important components of nurse education, interaction skills remain understudied.

Apker et al. (2006) found four communicative skill sets represented nurses’ professionalism in their health care team interactions; they were: collaboration, credibility, compassion and coordination. Apker et al. (2006) revealed that those interviewed regarded that these skill sets exemplify a professional nurse as someone who goes above and beyond basic job requirements to maximise the communicative effectiveness of the team and enhance patient outcomes. As will be seen from the responses of the NESB nurses, such ideals were not reflected in this study. Rather, interactions were frequently intermingled with behaviours such as discrimination, aggression,
exclusion and humiliation. The implications of these interactions were manifested in communication difficulties and the allocation of menial tasks. Constant interruptions from the care of the patients that had been allocated to the NESB nurses occurred in order that they help other nurses in other sections of the unit, mainly with menial tasks. This, according to some NESB nurses, led to limited learning opportunities arising from limited opportunities to familiarise themselves with the nursing care needs, pathophysiologies, nursing documentation, and diagnostic and therapeutic interventions relevant to the patients who had been allocated to them to manage.

Routines and rituals associated with the delivery of nursing care and the cultural basis for those routines challenged the NESB nurses’ understanding of the clinical learning environment. The perceived impact of such practices were on the patients’ right to choose, and the seeming absence of adequate assessment of the patient’s condition by some clinical nurses prior to the imposition of the hygiene ritual. Some NESB nurses also reported that there seemed to be a lack of understanding on the part of hospital staff regarding their role and learning needs as undergraduate students. The NESB nurses were, on occasion, allocated to work with agency staff, Division Two nurses, and inexperienced graduates who were expected to provide mentoring and clinical education to the NESB nurses.

5.1.2 Difficulties Negotiating Learning Opportunities
The NESB nurses reported a range of issues that impacted on their learning opportunities in the clinical environment. In attempting to explain the phenomenon, the nurses cited such factors as the belief that the staff were just too busy, that senior staff did not want to work with them, that they were not trusted, were on occasions allocated to work with a Division Two nurse, and
the intolerant behaviours of staff in relation to their lack of contextual knowledge and language difficulties. Fourteen participants were interviewed including the “Discriminant Case” and of those who commented on their experiences with staff support and the availability of learning opportunities in the clinical environment, two reported positive experiences and ten reported negative experiences.

Cultural issues were also a major factor impacting on the nurses’ learning experiences. One of the most frequently cited examples related to cultural practices in Australian nursing such as routines and rituals associated with the provision of hygiene and the prominence and significance attached to the practice by Division One nurses.

The following are some examples of the issues reported by non-English speaking nurses regarding the difficulties they encountered with gaining meaningful learning opportunities.

Alana a nurse of South American origin who had not practised for a number of years, put forward these comments:

Some classmates not given opportunity to learn not trusted.
That is a problem. We came to practice to see the difference, they want to leave the course because there is no one to help them. Alana, PG4: Ln6

Once a buddy made me feel worse than a student, constant criticism, very rude manner. I feel really bad when I was about to give Heparin, when I was about to give [sic] she just took it from my hand in front of the patient and did it herself and said ‘We have to do it quickly.’ Alana, PG4:Ln 10-11 & PG5:Ln1
Mei Li, experienced nurse of Chinese origin who had specialised in operating room work for a number of years, made these comments in relation to the availability of learning opportunities:

*A lot of things we have to do ourselves, and they say ‘You are qualified nurse you have to know that.’ I am lucky I have permanent nurse look after me, two nurses only have Agency nurse look after them. Agency nurse and Division Two, I don’t care if Division Two or Division One but sometimes the Agency nurse they don’t have responsibility to teach you lots of things. Agency nurse said “You are qualified nurse, you’ve got to know that” but I think if we know that why are we here? Mei Li, PG3:Ln 1-2*

She went on to say:

*Monday I was anxious because it depends on staff, on Friday the nurse was aggressive. Some you follow will make you anxious and depressed. Some nurses are inexperienced and when you ask them they cannot answer and sometimes make you feel stupid. Mei Li, PG10:Ln 22-23 (Field notes: Entry dated)*

The work of Donaldson and Carter (2005) would seem to shed light on this concern. In investigating how an undergraduate educational program prepared students for practice, these authors conducted a grounded theory study with students of nursing. It was found that, amongst other things, students were looking for a mentor or a member of staff who was a good role model and who would allow them to observe and practice the modelled skill and behaviour. They concluded that confidence and competence seemed to improve when students were supervised by a good role-model. Support of this kind did not seem to be available at all times in the case of the previous
participant; nor was it evident at all times in the next case. These comments were put forward by Angeline, an Indian nurse, who had significant experience in intensive care nursing:

In some ward I worked very hard because the nurse with me if I asked some questions they don’t like to give more information.
This week I start in … and they don’t mind helping they give you opportunity and they are ready to teach. **Angeline, PG 5:Ln5**

It depends on the staff. Some say this is the time for you to learn, but some if I go for medication with them they will say you go and shower the patient. **Angeline, PG10:Ln3**

These three nurses in the above examples were all placed at different clinical venues.

At the other extreme however Nanette, an inexperienced generalist nurse of Indian origin, reported:

Actually we are getting more support from the staff they are very friendly with me. **Nanette PG1:Ln10**

The clinical environment is a complex and dynamic space, and although it can provide rich contextual learning experiences for the non-English speaking nurses, access to meaningful learning experiences can be complicated by a multitude of issues. It seems however, that the greatest single barrier to learning is grounded in the attitudes of nursing staff and the quality of the learning experience relies heavily on the attitudes and professional experience of individual nurses.

This may in part be due to what Edmond (2001) refers to as unrealistically heavy clinical workloads that leave little time for teaching. It is pointed out by
Rutherford-Dijkhuizen (1995) that little is written about job satisfaction in relation to nationality of the registered nurse. However, it is claimed by Rutherford-Dijkhuizen that job satisfaction was identified as a pleasurable reaction to recognition as a professional and member of a group. The reports provided by the NESB nurses above would seem to indicate that such recognition as a professional was not present. Gail, a teacher, explained it this way:

> A lot of times they expect the students to do things but don’t give them any credit for it and a lot of times they give the students just stupid things to do, like for example your patient needs to go to theatre and you’ve got an admission and these are people that are really challenged with English and documentation. Gail (Teacher), PG2:Ln 1

> That is why I push early for them to take on a workload. Gail (Teacher), PG2:Ln 2

Gail suggested that the best way to insure that students were not just given disconnected tasks to do was to have them allocated to a particular group of patients, (this is what was meant by “workload” in this context) from the early stages of their clinical placement so as to avoid having disconnected tasks delegated to them; tasks with no real learning quality:

> The students think I’m really cruel doing that, but I explain to them that they don’t [just] get pushed into a round of obs. (observations). Gail (Teacher), PG2: Ln3

This seemed to be an issue across clinical learning environments, not just in different units in an individual hospital, but in all of the hospital facilities where the NESB nurses (often referred to as student nurses by teachers) were
placed. This will be highlighted a little later in a comment from a teacher at a different venue from the teacher quoted above.

Napthine (1996:23) expressed concern at what he described as abuse of the clinical placement system in terms of the use of students as de facto rostered staff. Napthine’s study related to undergraduate students of nursing who were enrolled in a three-year undergraduate program. However, ten years down the track, the same issues prevail in the case of NESB nurses who are enrolled in a CBAP. This is evident from this teacher’s insistence that students need to be assigned supernumerary status in order to avoid the problem of them being treated as what was described as “general body helpers” as distinct from learners:

> I respect the fact that student nurses don’t have to be trodden on either, they are there to learn a certain thing not to be used a general body helper, I’ve seen that happen, with those that really want to help, and then there are others who stand firm and know they are not there to be treated like the “dogs body”, whereas it might not be taken that way by a Division Two supervisor. She’ll come and say, she didn’t want to help with the rest of the patients. But she’s not there to help with the rest of the patients she’s there to learn her role as a Division One nurse. Leanne (Teacher), PG6: Ln2

It could be that when students want to help they are hoping to gain learning experiences and acceptance in exchange for that help. This was a trait that emerged in a study conducted by May and Veitch (1998) when an undergraduate student in referring to trading labour for learning experiences had this to say:
Initially if you do get on and do the graft, then they’ll think...she’s okay and then you get to see the observing bit. (May and Veitch, 1998:635)

At this time however, it seems that there is a problem with the availability of Division One nurses to mentor the NESB nurses in the clinical environment, either because, as one NESB nurse pointed out, the Division One nurses don’t want to work with them, or they are not sufficient in numbers to carry out that role:

*They don’t have enough Division One, maybe thirty percent of the time, so it’s not uncommon.* Leanne (Teacher), PG6: Ln3

There are at least three issues that emerge from this comment, the issue of the seeming isolation of student nurses (in this case NESB nurses) in the clinical environment, the learning opportunities, and the issue of supervision by Division Two nurses. This last issue also received comments from the NESB nurses in this study. At times the nurses described the distressing experience they felt through lack of support for learning in the clinical environment. Lei, a nurse of Chinese origin who was a paediatric nurse for ten years, reported the following situation:

*Staff [sic] is not very supportive especially senior staff they don’t want us working with them. Sometimes the charge nurse say can you work with another nurse,[sic] actually the other nurse is Division Two. I think if I work with Division Two I can’t know whole procedure how to perform in the hospital. But Division One, don’t want to work with us I don’t know why. Last Thursday I do an evening shift, I chose two patients. I want to do drug round and other procedures with my patient and the Division Two asked the Division One if I can to do, and*
the Division One nurse said, "No they only thing they can do is observe. So I feel really surprise [sic]. Then I ask my educator and my educator say I can do under supervise [sic]. I think it’s because they are so busy they don’t have time to talk with us. Lei, PG1:Ln2-3

It appears that this nurse came up against what Hawthorn (2001) described as peer rejection, and what Jackson (1995) viewed as obstructive behaviours. Here the nurse described her attempts to negotiate learning opportunities in the workplace and in order to facilitate that, she arrived at the clinical environment with prepared learning objectives in keeping with Rodger’s (1988) (cited in Delahey, 2005) view that adults come to the learning environment with agendas. Secondly, she was assigned to work with a Division Two nurse and was concerned regarding the limitations that placed on her opportunity to practice procedures such as medication administration and other procedures because of lack of appropriate supervision.

This gives contextual meaning to the suggestion made by Williams (2000:15), that the importance of organisational culture cannot be ignored in promoting or hindering the acquisition of various types of nursing knowledge in the clinical environment. In what appears to be a congruent comment, Billett (2001) advised that meaningful learning in the workplace does not take place by chance, but rather where there is a meaningful workplace curriculum and supervisors who possess the skills and knowledge to act as facilitators of learning, and have the time to devote to that task.

Before discussing the learning issues here from a theoretical point of view, it is important to articulate the professional and policy issues associated with
the practice of allocating a Division Two nurse to supervise a Division One nurse in a CBAP. It is a requirement of the Nurses Board of Victoria that the clinical supervision of undergraduate nurses be provided by a Division One nurse. It is difficult to understand the motive for allocating a Division Two nurse to carry out this function.

A Division Two nurse in the state of Victoria undertakes a one-year training program aimed at providing training in basic patient care such as the provision of hygiene, and other forms of basic personal assistance to patients who’s physical and mental status is deemed to be stable. These functions are carried out under the supervision, direct or indirect, of a Division One nurse (ANMC, 2004). The meaning of direct, as distinct from indirect supervision, is clearly defined in the policy document (ANMC, 2004). The function of a Division Two nurse does not include supervision and education of student nurses at any level.

A Division One nurse on the other hand usually undertakes a three year Bachelor Degree in the tertiary sector, although there are variations in terms of the alternative entry for graduates from another discipline (Ogle et al., 2002 cited in NRNE: Discussion Paper, 2002). The Division One nurse is considered to be a first level nurse, is permitted to practise without supervision, and is accountable for actions taken and decisions made.

It is clear then that a Division Two nurse, apart from perhaps providing a basic orientation to the clinical environment, is not equipped by virtue of education, training and experience, to provide meaningful clinical education and supervision to an undergraduate Division One nurse. In the case of this study, that includes NESB nurses. To assign such responsibility to a Division Two nurse is not just unreasonable, in terms the responsibility placed upon
the individual Division Two nurse, but is in fact a blatantly irresponsible act in terms of patient safety and the quality of undergraduate nurse education.

To return to the point of the nurse arriving in the clinical environment with pre-prepared learning objectives, this could be interpreted as an indication that the nurse was in a state of preparedness or readiness to learn (Rodgers cited in Delahaye, 2005). The issues for the nurse, however, were that she was allocated to work with a health professional who was not academically and professionally prepared to the same level and did not therefore possess the skills and knowledge to act as a facilitator in that situation as pointed out by the NESB nurse in question.

According to Delahaye (2005:16) facilitating adult learning is fundamental to the existence of human resource development. A useful insight into the application of Delahaye’s view, as it relates to the clinical environment, is to be found in (Benner, 1996). Benner speaks about the learning environment in relation to what she describes as the “advanced beginner”. It is not intended here to classify non-English speaking nurses in accordance with Benner’s trajectory. However, Benner’s theory of learning in the clinical environment is likely to be applicable in a range of nurse education situations. According to Benner (1996:75) it is imperative that advanced-beginners work in environments where they feel safe asking questions and it is important that their clinical inexperience is not judged as a personal inadequacy. Benner also points out that environments that are interpersonally threatening to the nurse and punish early mistakes in judgement, or set up barriers to the free flow of questions, are most hazardous to patients. This is a view also noted by Braito and Caston (1983) and Gifford et al. (2002).
Chapter 5  
Teaching and Learning: Clinical Learning Context

As far as clinical learning is concerned, it is impossible to separate the experience of learning from conditions of work in a particular environment, and this is especially so for the overseas qualified nurse because of previous professional experience. Non-English speaking nurses in clinical practice must reach their required level of competence by actually being involved in direct patient care, and this is an activity that by its very nature requires them to engage with the community of practice.

Some participants reported positive experiences and most participants reported a mixture of positive learning experiences and alienating behaviours exhibited by clinical nursing staff. However, reports of positive experiences emerged less frequently and there were variations between clinical venues particularly in relation to the perceived discriminatory and unprofessional behaviours on the part of nursing staff.

*Some staff very nice, some not nice, when I meet the very nice staff I feel very happy and I think I learn a lot then I meet not nice and I have to do all the things, but in the future you will also meet difficult situations [sic] working in Australia.*  
Lei, PG12:Ln1

I asked Leanne, a teacher, if there were ways and in what ways these nurses’ existing skills manifested themselves to her. Her response seems to validate the feelings expressed by the last two NESB nurses:

*Ya, they become very confident with some positive feedback from the staff and towards the end some of them could complete the tasks on their own without supervision and prompting.*  
Leanne (Teacher), PG1:Ln6
However, comments of this nature were in a minority, with many nurses reporting feelings of rejection and alienation and significant difficulties securing meaningful learning opportunities. In addition, all teachers regardless of the venue at which they worked, emphasised the importance of supporting students in their efforts to access learning opportunities as distinct from being allocated discreet tasks of a heavy and menial nature.

In the interview with the Australian born and educated nurse ("Discriminant Case") it was revealed that, at the opening stage of the interview, there were two issues that challenged her and one of those was as follows:

Clinical placement on the ward didn’t feel welcome. My first shift [the] girl did not want to have a student and left me on my own and we had been told to stay with our buddy and she left me on my own. At one point I went to the toilet and trying to hold back the tears and a few days later a colleague (NESB) had the same nurse and she then could understand what I went through. It really depended on the nurse you got. The real problem, the nurse unit managers did not clearly explain to the staff what was required of them or give them an option to maybe not have a student. It would have made it a far better environment if we had someone who was agreeable to take us. Things did improve by the end of the third week probably got used to us. Susan ("Discriminant Case"), PG1:Ln8-9

The feelings of lack of support in the clinical environment were sometimes compounded by the fact that the nurses believed that the current 1:8 student/teacher ratio for university based clinical support was inadequate. Although, the presence of the clinical instructor did at times provide a sense of spatial and educational security.
Mei Li, who was an operating room nurse from China, made this comment:

*It is important to have a clinical teacher, but 1:8 not enough.*

*We have two debrief Tuesday and Friday, but they not ask about concern they just tell us what we do wrong.* Mei Li, PG6:Ln10.

It may be at this point that questions regarding the implications of the clinical teacher model are being raised, particularly in relation to the experiences of Mei Li, and indeed such questions sprung to mind when the nurse spoke of her experience during the course of an interview.

Thirteen other participants commented in relation to the adequacy of the clinical teacher model as they perceived it in practice. All of the NESB nurses believed that it was important to have a clinical teacher at the clinical venue. The responses pointed to a number of issues and these related to the complexity of the clinical environment, difficulties associated with contacting the teacher, and difficulties with gaining prior knowledge regarding scheduled procedures such as wound dressings and suture and drain removal. These issues hindered access to learning opportunities as this comment from Mei Li suggests:

*Only one for eight students so, you have to call her to do the dressing, the antibiotic, whatever. And the nurse you know they are not teaching, just asking you to do things. We need to do things but we still have to learn.* Mei Li, PG9: Ln2.

One clinical teacher cited occasional lack of appropriate learning opportunities in terms of procedural practices due to the absence of some procedures in some clinical environments. For example, a nurse may be assigned to a medical unit for the duration of her/his clinical placement.
The opportunity to observe them doing sort of thing. Whether
the opportunities are there and available on a particular ward;
if you’re on a medical ward and you want to observe a more
complex dressing then that’s one factor. Donna (Teacher),
PG11:Ln2.

The same teacher questioned the structure and scope of the current
assessment tool citing inappropriate expectations of the NESB nurse given
that there were rarely sufficient opportunities for nurses to demonstrate
competence in all domains incorporated in the competency assessment tool.
In response to a question on the value of the current assessment tool, Donna
offered this response:

Do you want to get me started on that, I think the Domains
form the ANMC are quite good areas to look at. There are a few
areas that I think are fairly iffy. I don’t think either
undergraduate students or these kind of students [NESB]
really get a chance to demonstrate those areas because they are
more for qualified nurses and that’s one of the problems with
ANMC. I think the Bondy Scale would be quite useful. It could
show the student you require this and you require that for
example to work independently move up the Scale. It would
give the assessor a clear idea. Donna (Teacher), PG11:Ln1-2

Donna did indicate, however, that it is very important to retain the clinical
teacher model particularly for non-English speaking nurses, but conceded
that the system is not without limitations:

Oh, very, very important they need the consistence of one
person. The way the wards work each shift they tend to get
“buddied” with some one, so they get a bit of both, but I think
it’s better if they have a clinical teacher, (as distinct from a preceptor) because you’ve got such a short space of time with their assessment a clinical teacher has to get a grip of what they’re performing like overall. Donna (Teacher), PG5: Ln2

This view was shared by Leesa, an experienced generalist nurse from the Philippines:

Oh it’s very important because with your buddy you are not learning from them because it’s not their responsibility to teach you because they are busy and you are just annoying them or disturbing them from their paperwork. I am not learning a lot from them, which is my problem. They are not helping us they want to work by themselves. Leesa, PG4:Ln9

The limitations of the model, however, were also evident from an account provided by Leanne, another teacher. Leanne indicated that getting to see the NESB nurses was an issue in view of the range of clinical locations within one facility and the dynamic nature of the environment. This meant that the teacher could never rely on finding the NESB nurse in any particular place within the clinical unit:

Sometimes I can’t even visit them, it takes time to go from ward to ward and sometimes you can’t see the student when you get there because they are involved in patient care or doing something with the nurses. Leanne (Teacher), PG4: Ln2

The issue of availability did seem to be an area that most teachers and students viewed as problematic given the one to eight ratio and the complexity of the clinical environment:
There are eight in this building and we are all in different places and we can’t have her all the time to ask her, she’s not always there to help you and you find yourself out of nowhere, nothing you can do because you cannot find her. Leesa, PG5: Ln1

However, a teacher indicated that when there is an opportunity to perform a procedure that in fact it is an ideal time to see a student (NESB nurse):

If they are preparing to do a procedure and they call me that is a good time. Sometimes they don’t page me even though you encourage them, they are frightened to use the phone. Leanne (Teacher), PG4: Ln2

Another teacher, Donna, reported a similar view in terms of the issue of the students (NESB nurses) letting the teacher know when teaching support is required:

Another factor is the student letting you know some want you all the time whereas other students will never call you or hardly ever [it’s] trying to get a nice balance. Donna (Teacher), PG11: Ln2

This issue is further highlighted in this comment from one of the NESB nurses:

We can page her when we want her, but most of the time I never call her. Louise, PG2: Ln1

It’s really good if we have any problem or if we are not coping with nurse or anything in the ward we can tell her and for everything she is helping. Louise, PG3: Ln2
The “Discriminant Case” shed further light on the problem of access to the clinical teacher:

The ratio of students to clinical, one to eight is far too high. The others got one to three and others got one to four. I wrote this in the evaluation. What they did at … hospital, the teacher would spend a whole shift with one student and a whole shift with another so there was continuity and she would know you at that stage and know your needs and you didn’t [sic] feel such an idiot (emphasis placed by Susan). I found with us we were getting fragmented care because of the sheer volume of students. If we had two clinical teachers for the eight over the six weeks we could have six days of coaxing and she would have weaned us off. Susan (“Discriminant Case”), PG2:Ln7

This comment supports the views of the NESB nurses that the one-to-eight ratio is not sufficient to meet the needs of this group including the re-entry category. It would seem that if the ratio is viewed as problematic by an English speaking nurse then it would raise further questions regarding the adequacy of the model for non-English speaking nurses.

There were also instances where the teacher-learner interactions seemed totally incongruent with the provision of a positive learning climate. Whether or not this kind of experience explains the nurses’ reluctance to call the clinical teacher is not clear, but it is probably not unreasonable to suspect that it may be a contributing factor in some instances as this journal entry would seem to indicate (Underlining was the work of Alana):

The clinical teacher was here this morning and once again she asked me to read the medical orders. In this occasion it was much more difficult than before [underline was the respondents
emphasis], because I could not understand the doctors hand writing. My teacher also could not understand the medical order. When I tried to read it I unknowingly repeated what my teacher had read earlier at this she got really mad and made me feel really bad. Her attitude toward me is very inappropriate and once again I am thinking of talking with my co-ordinator.

(Alana: Journal entry: Entry dated)

Three days after the previous entry: Today I tried to organize myself better and to complete all the procedures concerning all my patients so my teacher would not be angry (underlined by respondent), because I still need to do something [sic]. (Alana: Journal Entry: Entry dated).

Immediately following completion of the course:
It was my first experience with the clinical teacher in…hospital long explanation here. She’s always asking me things I don’t know then I feel guilty and stupid and I feel it’s not good for me to practice like this, but when I go to other hospital I could learn because I was not in the pressure [sic]. The teacher there ask [sic] me things, I was expecting it to be very difficult, but it wasn’t that difficult. Alana, P7:Ln6

It is one thing to talk about nursing curricula and models of clinical education, but yet another to confront what could be referred to as the “messy swamps” (Street, 1990:1). The term is derived from the work of Schon (1983:42) where he contrasts what he refers to as the “high hard ground” that is, of rigorous professional knowledge where problems are amenable to solutions, with the “swampy lowlands” where situational problems are
confusing, may defy objective solutions, but are often of the greatest human concern. One such area that is worthy of comment here is the professional behaviour and attitudes of nurses and how this impacts on the clinical education of non-English speaking nurses while they are enrolled in CBAP.

Behaviours such as those reported by the non-English speaking nurse above could be attributable to a number of factors in the clinical environment. However, the following may provide some possible explanations. Griffiths and Crookes (2006) point to the impact of dysfunctional conflict on harmony and outcomes. It is also suggested that aggression is a feature amongst groups such as nurses who have low self-esteem (Farrell and Gray, 1996). It was indicated in the Jones and Cheek study (2003) that nurses did not feel valued by other health professionals with whom they worked and by the organisations in which they were employed. It is suggested here that whatever the reason for such behaviours, the impact of those behaviours lead to a degree of dysfunction in terms of the utilisation of the clinical environment as an educational facility and to this extent the current ills in the profession are likely to be perpetuated.

One of the more difficult aspects of understanding the behaviours that the NESB nurses described is that nurses, by the very nature of their professional location within a multidisciplinary team and their role in providing care to people from a vast range of cultural and socio-economic backgrounds, are no strangers to diversity (Contreras, 2005). Indeed, the concepts of cultural diversity and cultural competence have received considerable attention in nursing curricula over the past decade or so. It is deemed to be one of the most challenging aspects of nursing, that is, the association of culture and values and their application to care (Cortis, 2003).
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Possible explanations for unfriendly behaviours in the workplace offered by Griffiths and Crookes (2006) that may be applicable in this case are that team members may be unclear about their role, there may be lack of clear jurisdiction in terms of accountability, authority and responsibility within the team, poor communication, and incompatibilities based on difference. It could also be attributable to hospital restructuring, increased productivity and poor morale, as well as the lowered status of nursing as a predominantly female profession (Gifford et al., 2003).

One clinical teacher in this study put forward a view that coincides with the views of (Griffiths and Crookes, 2006):

*It could be lack of communication due to pressure at work or language barrier and some of the nurses have accents as well. Expectations not defined.* Leanne (Teacher), PG3:Ln2

It is not clear from the NESB nurses’ accounts which of these factors influenced the responses of Division One nurses in terms of their apparent reluctance to work with NESB nurses. However, a possible explanation may well be a lack of clear understanding of their role and the position of management on such matters as the provision of clinical supervision and mentorship to students in the clinical setting. It is also possible that the learning needs of the NESB nurses are not communicated clearly to nurses in the clinical setting. This is a view also expressed by a clinical teacher:

*Needs to be explained to the nurse what competencies the student needs to work on.* Leanne (Teacher), PG3:Ln2

Operational issues such as staffing shortages and poor skill mix are sighted as contributing to aggression in the clinical setting (Farrell and Gray, 1992). It is acknowledged that staffing shortages have greatly altered the work of nurses
in the Australian context in recent years (Jones, 2002; NSWNA, 2002) And, it is noted by Bone (2002) that mixed emotions and ambivalence are feelings that are prevalent in contexts of increased complexity and shifting demands. The fact that the staff may be too busy to facilitate students learning was commented on by participants in relation to the nurses’ reluctance to work with them and the volumes of work allocated to some students (NESB nurses):

*Not enough staff, it was unfair not enough time.* Mei Li, PG9:Ln3.

The extent to which ward nurses seemed busy was also cited as a significant reason to retain the clinical teacher model:

*In the beginning it was difficult for us because we don’t know things and we have to disturb them so they will feel something because we have to go and ask them everything.* Louise, PG2:Ln2

Are these possible explanations enough though, to excuse or justify many of the behaviours directed at the non-English-speaking nurses? Or, is it possible that nurses as individuals frequently or infrequently abandon the philosophy of humanism, a philosophy that according to Walker (2006) is especially attractive to a profession such as nursing, which has humans and their interests as the main focus of, and the reason for, its very existence. It is a profession that, according to Gardner (2005), values empathy and caring. These thoughts may give rise to more questions as the next phenomenon that impacted on the NESB nurses’ learning opportunities is explored, that is, routines and rituals in the clinical environment.
5.1.3 Routines and Rituals: Impact on Clinical Learning

Routines and rituals are an important element of nurses’ work. Many are handed down through the oral tradition (Street, 1992) and perpetuated from one generation of nurses to the next. Such routines, while part of the everyday practice in the work of the Australian nurse, are for some newcomers questionable and regarded as physically demanding, menial, unnecessary and a waste of time. In some cases they are felt to be invasive for the patients and in fact violate the patients’ rights. Similar concerns were raised by a group of new graduate nurses in the United Kingdom. The study conducted by Mayben et al. (2006) revealed what is referred to as the hidden reality that physical care takes precedence over psychological care.

Attention was drawn to the issue by six participants including the “Discriminant Case”. The remaining eight out of fourteen did not comment. However, given the strength of the views against the practice of Division One nurses spending significant periods of time on personal hygiene and other tasks that were regarded as menial, it is deemed to be noteworthy here.

This generalist nurse from El Salvador expressed the following concern:

I know we have to shower the patients every day but what about when the patient doesn’t want to shower and we say you have to take shower and if they say why can’t I have it after lunch we say you have to have now. Why can’t it be flexible, it’s alright if the patient doesn’t shower for three days, if the patient is wet or smelly then we shower. When we do that we show them they are not in their home they are in the hospital.

That is my thinking. Alana, PG5:Ln7
This nurse questioned the impact of the routine on patient morale as well as the control factor embedded in this ritual. It is suggested by Foucault (1975) that when an individual becomes ill and enters an institution the boundaries of what might be considered normal in society are breached, a contention that according to Mallik et al. (1998) has particular implications for breaking the rules of privacy associated with the delivery of hygiene care.

Nelson and Greehan (2006) suggest that in order to understand current issues it is worth shedding light on the past, and to that extend it is worth noting at least one possible explanation for nurses’ concern with hygiene. The obsessional concern of nurses with hygiene in institutional life, according to Mallik (1998), can be traced back to the Poor Law in Britain in the 1800s and the association of dirt with disease and poverty (Jones, 1994).

A specialist nurse of Chinese origin expressed concern with the amount of time nurses spent on showering and bed making and other menial tasks at the expense of more advanced and therapeutic measures associated with patient care and safety as well as the nurses’ personal safety.

*For learning there is nothing different between here and China except here you shower patients and if the patient spill something on the floor you have to clean it up. I think they can save by having PCA (patient care assistant) shower and sponge patients who are stable.* Mei Li, PG10:Ln24-25

*The nurse sponge or shower so in between that they have to go to writing reports so they are not caring for the patient much.*

Angeline, PG10:Ln1
An experienced generalist nurse from the Philippines explained the difference in this way:

*The time for patient management is different because nurses are worried to finish their showering and their bed-making these things can be done by a nurses aid, and sometimes the quality of care was [sic] being at stake because you have to do the beds and the showering everything.* Leesa, PG5:Ln3

Angeline, an experienced nurse of Indian origin, expressed concern regarding the manner in which some nurses insist on the routine of showering regardless of the patient’s wishes and in some cases, according to this source, without an adequate clinical assessment regarding the appropriateness of the action at a given time:

*Yes, I think that showering the patient most of them before they make any other assessment [sic], like if the hands are very warm and bluish or very cold and bluish, and the patient say I don’t want to have a shower, they say you will feel better when you have a shower. They will insist on taking the patient to the shower without assessing why the patient is complaining, or if the patient had the same yesterday. Yesterday she may be ready for a shower and today she may be more weak so they don’t think [sic] that.* Angeline, PG10 Ln2

One participant of Eastern European origin believed that showering the patient was an important part of the work of the registered nurse. This was at the other extreme of the usual range of responses:

*It’s part of the nursing job, I think as a registered nurse I think it helps build up relationship and trust and [they] will have respect for you as Division One.* Deanne, PG4:Ln 9
It is not intended here to deny the necessity to provide hygiene care to patients who are not capable of attending to that aspect of daily living at a given time, nor is it intended to dispute the practice of providing assistance with hygiene practices to people with varying degrees of disability. However, it is intended to point out that the delivery of nursing care requires a degree of situational responsiveness. According to Edmond (2001), responsiveness to situational variables that is underpinned by ethical and human qualities is precisely what differentiates nursing from technical and procedural care that could be carried out by robots. It appears then, that in the light of the responses above that three significant concerns are being raised, each of these are discussed below.

**Duty of Care**

Firstly, there is a duty of care issue which is made more complex due to the fact that a registered nurse has to function in a highly litigious environment (NRNE: Discussion Paper, 2002). Secondly, there is a question of choice and the patients’ right to refuse interventions as a full common-law right (Staunton and Chiarella, 2003:125). Also worthy of consideration here is the related ethical principle of autonomy which, according to Johnstone (1999) “is to be taken seriously by nurses, nursing practice must truly respect patients as dignified human beings capable of deciding what is in their best interest even if what they decide is considered by others (including nurses) to be foolish”. Finally and most importantly there is the question of whether the provision of basic hygiene to patients needs to be the domain of the Division One nurse. Currently it is claimed that nurses face a “highly technical and rapidly changing environment where nurses are expected to work from an evidence-base” (NRNE: Discussion Paper, 2002) and claims that the supervisory role of the registered nurse will, in the future, expand because of the introduction of unskilled and unqualified health workers and the increasing complexity of
health care delivery systems (NBV, 2006). Further, the role of the nurse has changed from being a person who practised modified medicine, to a person who appreciates the dynamic and evolving nature of nursing, and is able to use the skills of inquiry, critical thinking, problem solving and reflective practice (Conway and McMillan, 2006). Given these skills, nurses should clearly be capable of determining if the patient is sufficiently stable, mentally and physically, to be transported to a shower facility. Or, is the reality of daily practice for the Division One nurse simply not congruent with what Herdman (1983:44) refers to as the rhetoric of the dominant group in nursing.

This possibly relates to what Street (1992:6-7) refers to as the task/responsibility dichotomy in which nurses have been traditionally socialised into routines and task-based practices interspersed with tremendous responsibility for people’s lives and the legal implications of that responsibility. It appears that it is these kinds of responsibilities that the respondents were focused on when they spoke of their experiences. Street (1992:8) also points out that historically nursing action was not expected to flow from careful analysis of needs but rather from an unquestioning adherence to rules and rituals. And it appears, from the concerns expressed by the respondents cited above, that little has changed in this regard despite the introduction of the nursing process in the 1970s as a means of ensuring that care is individualised (Walsh, 2002:9).

**Skill Utilisation**

It is also worth considering that there is another possible and more contemporary explanation for the phenomenon of Division One nurses being both obsessed with, and heavily involved in, the provision of basic hygiene care: the issue of deskilling.
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Herdman (1998) utilised an ethnographic approach using participant observation, in-depth interviews, document analysis and discourse analysis to examine the transformation of nursing work in a New South Wales hospital from 1970 to 1990 from a perspective of practising nurses. Herdman’s findings raise some important questions regarding the status of nursing in relation to autonomy and the realities of daily practice in the clinical environment. In a skilful introduction to the presentation of her finding Herdman refers to the succinct argument of Buckenham and McGrath (1983:42) that:

> If the profession’s perspective of nursing is shared by the members of that profession, then any investigation of nursing practice should reveal a consistency between the behaviours manifested by the practice and those implied by the image projected by the profession. (cited in Keleher and McInerney (Eds.), 1998:35).

While the purpose of this study is not to investigate nursing practice per se there is no doubt that the practice environment is a major contextual factor in relation to the educational experiences of non-English speaking nurses who are enrolled in a CBAP, and to that extent it features prominently in the investigation and analysis of their experiences.

In exploring the work experiences of Division One nurses over a twelve month period Herdman revealed widespread dissatisfaction with the nature of the work that the nurses undertook on a daily basis. Herdman’s findings revealed that nurses’ main concerns related to what they viewed as a deskilling process that had gradually taken hold since the transfer of nurse education to the tertiary sector, the increasing specialisation within the ranks of nursing, and the proliferation of allied health professionals such as
physiotherapists and occupational therapists. Herdman’s observations revealed that of all the nursing functions carried out by staff in the clinical environment, only four were carried out exclusively by Division One nurses and these were: i) the administration of medications; ii) insertion of urinary catheters; iii) intravenous therapy; and iv) electrocardiograph readings (Herdman, 1998). All other nursing functions were carried out by Division Two nurses, ward assistants, and other unregistered personnel. Many Division One nurses reported that their work now was exactly the same as when they were students:

Basically today I’m doing the stuff I did as a student…most of the junior nurses’ work…but I also have to do the other stuff…be responsible for the ward…any emergencies…it’s first, second and third years all rolled into one…but no more teaching…no more managing…that’s specialists stuff now…I’m back where I started with all the rotten work and none of the interesting stuff (Herdman, 1998:38).

These findings seem to present an incongruous view of the role of the nurse from the views presented by the dominant groups (Herdman, 1998). These were views that would appear to bear little resemblance to the day-to-day experiences reported by the participants in this study nor, indeed to reports that emerged from Herdman’s study, although the two studies were undertaken close to fifteen years apart.

In advancing the above opinions regarding the apparent incongruities between the accounts from the clinical environment and those put forward by professional bodies and scholars, it is not intended to deny, devalue or question the past, present and future complexity and diversity of the health
care environment and the role of the registered nurse within it. Moreover, the intention is, in fact, to support such views in terms of the need for a strong intellectual underpinning to the professional education and the need for all registered nurses to reflect critically on their own professional practices and job design to ensure that their skills and knowledge are utilised appropriately in the delivery of health care. And it would appear from the accounts of the day-to-day practice of the registered nurse provided in this study that critical reflection is not a strong feature in that environment.

5.1.4 Deskillling

This participant raised a question that seemed to mirror the findings of Herdman’s work. Mei Li, a specialist nurse of Chinese origin, offered this comment in relation to the task of showering patients:

I don’t think it’s fair for the nurse to have three years Bachelors Degree so after three years you shower the patient. Mei Li, PG13:Ln 2.

This statement from an Australian born and educated nurse who was interviewed as a “Discriminant case” also reflected Herdman’s findings. When discussing the allocation of duties and the patient allocation system in the hospital where she did here clinical placement, she had this to say:

I feel I’m just back to the little junior. Susan (“Discriminant Case”), PG4:Ln2

It is interesting to note that when I asked Donna (Teacher) if the nurses were at a similar level of professional knowledge to that of an Australian nurse the teacher responded:

I think they are, but I think it goes back to the way the work in their own home system [it’s] different. From what I can gather
from the different things they talk about they don’t seem to get too much about personal care of people, the families do that.

Donna (Teacher), PG2:Ln2

The above response and this one from Leanne, also a teacher, seems to reflect a view that professional competence in Australia is inextricably linked with the nurses’ ability and willingness to be involved in the basic personal care of patients:

She (NESB nurse) had to first realise the routine, so it was quite a challenge for her and perhaps in her country they didn’t have to do basic care a couple of them talked to me about that whereas here she had to do washes and pans. Leanne (Teacher), PG1:Ln4

Comments the NESB nurses made during the course of the research not only questioned the task of showering per se, but also the occupational health and safety issues associated with it.

Today I saw registered nurse do 60% of what is PCAs (Patient Care Assistant) job. [We have] “No Lift Policy”, but if patient too heavy you still have to give her shower. How do you do it? Mei Li, PG11:Ln 9-10

The difficulty I find for the nurse, there will be four or five patients, and if the patients are bed ridden you need someone to help with those patients. But difficult to get help everyone [sic] busy with their own patients so get the nurse to position (the patient) it’s very difficult, otherwise we can manage. Evelyn, PG12:Ln1
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There were also times when it seemed that NESB nurses were merely utilised as pairs of hands for the completion of heavy manual work as evidenced by Mei Li, an operating room nurse from China.

*I’m so tired. Yesterday, I was looking after seven patients and they let me do all the showers and it’s so heavy in the mornings, it’s not fair; change wound dressings. The lecturer says you will have to learn to say no. How can you say no when you are student.* Mei Li, PG12:Ln12-15

I asked a clinical teacher if she observed that staff were inclined to use the NESB nurses as pairs of hands:

*Some people think I’ve got a student with me I’ll slack off and let them do all the work. Others really try and have input and try to help them learning things. It can be a culture in a particular ward.* Donna (Teacher), PG6:Ln 2

This attitude may well be a reflection of a workload that is extremely taxing on nurses in the clinical area and any relief from that is a welcome bonus. According to Armstrong (2004), the burden on individual working nurses is increasing with the increase in productivity related to an increase in hospital admissions by approximately forty-four percent over the last decade, the resultant level of acuity, and the associated need for more intensive nursing and support. It may be, on the other hand, a combination of an excessive workload and a hangover from the days when student nurses were the labourers of the health care workforce, an issue that raised concern in the early part of the nineteenth century (Ashley, 1976), and does not appear to have abated.
During one of the frequent observation sessions I spoke with and observed a nurse who was a specialist paediatric nurse of Chinese origin. I found that she was working alone in a different section to that where she had worked until ten o’clock on the previous night. It was a busy surgical unit and she complained of feeling tired:

*Worked until ten last night, started at seven this morning.*

*Missed meal break last night too busy. My buddy has gone to morning tea she doesn’t tell me when she is going, doesn’t ask me when I want to have a break.*

*I can’t assess my patients this morning. I have three, all require full assistance with hygiene then, I have to assist my buddy with her patients.*

Lei (Brown notebook Page 10:Ln1-19; pages written on both sides: Entries dated)

Lei was observed at various stages over the next one and a half hours following this comment. She seemed rushed as she walked briskly from one section to the other. (Field notes: Brown note book PG11: Entry dated) The area in which she worked was mapped in order to provide a visual representation of the frequent moves from one section to another during her clinical placement.

The Australian nurse who was involved in the study as a “Discriminant Case” was asked about her thoughts on the issue of the function of the Division One nurse. The ensuing conversation with her raised professional and safety issues relevant to staff and patients in the clinical environment:

*You’ve got to allocate the work according to what people can do. Division Two can be responsible for the more basic care.*

*Need to supervise [sic]. Showering, not necessary for Division One, but necessary that it is done. Because, you may be allocating a lot less time to the other important issues while*
doing basic care, it’s OK to help just like when we had undergraduate nurses, everyone is doing what they are trained for, work as a team. Susan (“Discriminant Case”), PG3:Ln3 &5

Susan also indicated that she believed that Division Two nurses were frequently allocated duties for which they were not adequately prepared:

Quantify of patients between all the staff that are there and, unless the Division Two has been qualified to do something you don’t give them a work load where someone else [has] to cover. Staff complained about it so many of them complained to me. I’ve got this to do and that and she’s not helping me. Let’s get some system in we are all here and lets get the best for the patient, but Division Two responsibility and my responsibility is… Susan (“Discriminant Case”), PG3:Ln7

It is noted by Barnum (cited in Benner et al., 1996:ix) that in earlier times the head nurse instinctively balanced case assignment based on her/his knowledge of the capabilities of staff. Barnum believes that historically it was possible to do this because not all patients were acutely ill. However, Barnum argues that in modern times because of the level of acuity in hospital wards the only solution to the skill match issue is constant teaming over the period of time that it takes for nurses to acquire expertise. However, Barnum points out that at a time when the situation requires dialogue in terms of mentoring new nurses, economically driven staffing systems leave little time for mentoring. Similar concerns have been noted by Mayben et al. (2006) regarding the concerns expressed by new graduates in relation to not being able to provide all the necessary care to patients in their care as this following comment form Mayben’s study suggests:
I feel quite sad that I’m not able to give my all to patient care... I still want to give my ideal practice as well as doing all the other hundreds and thousands of things that I have to do. So I feel quite drained. (Mayben et al., 2006:469)

I asked Susan what, in her opinion, was the cause of the phenomenon she spoke about:

> From what I’ve seen some Division Two nurses are very, very domineering and I don’t know if they’ve got “chips on their shoulder” or what, and to keep the peace the nurse unit managers tend to just allocate and just overburden the Division One. Susan (“Discriminant Case”), PG4:Ln1

Susan expressed the view that Unit Managers should:

> Let people know their duties. I’m really concerned about the Division Two situation. I was allocated a Division Two buddy, then those four patients drugs were allocated to four different Division One nurses. I was trying to follow people who were taking drug charts away so that they could know to give someone Insulin and I didn’t know where I was. If you’re not looking after that patient and you are administering drugs to them it’s defeating the purpose.

Having a big gap in my practice I really see it. But I felt I’m just back to a little junior.

**Why on earth do we do three years, what for?** [Susan’s voice was raised at this point]. I will put up with it for six months and then I will go back to ...purely because there needs
It would seem from this comment that skill mix is a significant factor in this case with Division Two nurses being allocated patients to care for without the necessary educational preparation to administer medications and manage intravenous therapy for those patients.

This raised an important point in relation to the safe administration of medications and the amount of time the nurse has available to spend with patients during the process of medication administration and a seemingly stressful workload for the registered nurse involved. All of which are factors that were reported by Deans (2005) as contributing directly to the cause of medication errors.

Buchan and Calman (2005:12) advise that any organisation that employs nurses needs to be confident that their skills are being well utilised. It would appear from many of the comments provided by non-English speaking nurses in this study that they believed that their own skills, and those of other registered nurses within the clinical environment, were not adequately and appropriately utilised. Buchan and Calman admit that there is limited, but growing evidence in relation to the effectiveness of skill mix in addressing staffing problems in the nursing workforce. Some reports indicate improved cost and quality improvements following the introduction of care assistants. However, other studies suggest that the scope of improvement might be more apparent than real with the latter studies arguing that decreased quality of care plus increased cost factors such as sick leave and overtime, higher workload for registered nurses, and higher turnover and absenteeism, paint a different picture (Buchan and Calman, 2005).
5.1.5 Language and Communication

Communication an issue reported by all participants as a factor that had significant implications for their learning and self-confidence both in the academic and in the clinical environment. However, these difficulties were more keenly felt in the clinical learning environment. Nursing students are expected to communicate well with patients, registered nurses, and other health care professionals. Students who have difficulties in this area face negative reactions in the clinical situation (Davidhizar and Shearer, 2005; Kilstoff and Baker, 2006; Shakya et al., 2000). Communication often creates the most insurmountable problems for nursing students (Davidhizar and Shearer, 2005).

The main areas in which communication affected the nurses’ daily encounters were in the areas of the nursing handover, the interpretation of medical orders, interpretation of nursing notes, and verbal communication with nurses. This was complicated by the use of abbreviations, accents, and the use of some forms of nursing documentation. Social communication with non-English speaking patients and the interpretation of their symptoms was also reported as problematic. This is what Benner (1996:125) refers to as qualitative distinctions, defined by Benner as the hallmark of clinical and ethical judgement. Such distinctions according to Benner are “laden with tone and emotional and attitudinal qualities, as well as action and contextual qualities”.

One of the most anxiety-producing issues associated with communication for NESB nurses was the process of providing the nursing handover. This is due to the fact that it may well be the first time that the nurse is faced with the need to speak to a group of professionals in English and to convey complex clinical information regarding the condition of the patients in their care.
The requirement to provide a nursing handover to the nursing team at the clinical venue occurs very early in the clinical placement. This issue complicates the experience for the nurse providing the report, not just in terms of language and accent, but also in terms of environmental and organisational factors such as familiarity with routines, policies and protocols. Comments regarding that experience reflected some humiliating behaviours towards the nurse. Nurses seemed to vent their own frustrations with not being able to readily understand the NESB nurse through using verbal gestures such as Ar, Ar, Ar., as evidenced by this comment from Lei, a nurse of Chinese background:

It’s a big concern for me because some nursing staff is not friendly when you do handover, some are laughing and some are doing Ar, Ar, Ar like this (Tape: 217), and it make me feel so uncomfortable. This have a big impact on me because I am afraid to do that handover again maybe I will refuse to do handover again. It make me nervous because once the nurse laugh at me then tomorrow that nurse could be my buddy and I’m afraid to ask questions, I will keep quiet because I’m afraid she will laugh at me again. Lei, PG6: Ln4-6.

I think this influence me because once they treat me very bad of course I’m reluctant to do some things and sometimes I want to escape. Lei, PG12: Ln2

Shakya et al. (2000) cited the view of Menon (1992) that the concerns of NESB students of nursing may be realistic on the basis that:

Australian nurses rarely listen for longer than ten minutes to someone whose pronunciation was difficult to understand. They became restless, they changed the
subject or they interrupted so that they could speak instead. (Shakya et al. 2000:166)

Donna, a teacher, explained that accents posed a problem for communication in the clinical environment:

_Not so much communication skills but the accents; some of it though, was communication. Some staff were very good very tolerant and very understanding with the students and would encourage them. Others were very “what are you trying to tell me can’t understand that forget about it” sort of thing._ Donna (Teacher),

PG4:Ln 2

This teacher was not associated with Lei, and these respective views therefore seem to be reflecting similar issues with communication from two different sites and two different perspectives, those of a teacher and a student (NESB nurse). This teacher, however, tried to place the issue in a broader perspective related to the quality and consistency of the English testing systems:

_I think some of the students do have some significant problems and, again I think there are some problems with the English language test that they do, sometimes give the level of English some of these students have and they have passed the same test I think there is wide variation. Had some who at the start of the course could hardly understand what we were talking about, and others who got worse results [in the English test] could actually speak a lot better. I think it’s an area if they haven’t got good English they tend not to do so well._ Donna (Teacher),

PG4:Ln2
This comment is in keeping with the findings of Shakya et al. (2001) that despite the fact that students have achieved the requisite score in the IELTS, this level of English was not necessarily adequate to enable undergraduates to study nursing because of the complex nature of the communication skills required.

Gail, a teacher at a different site, believed that anyone with a different accent was regarded as stupid:

\[
\text{A lot of staff treat the students, (NESB nurses) as if they are completely stupid, anyone with an accent is automatically considered an idiot. They will speak really fast and not repeat themselves and then they just come and tell me that the student can’t speak English. Gail (Teacher), PG1:Ln8}
\]

Nonetheless, the NESB nurses themselves also expressed concerns regarding their communication skills as this nurse of South American origin explained:

\[
\text{Very nervous about communication in the clinical environment, they try to make it short and it’s hard for me to know what they exactly are talking about. Lots of abbreviations and I feel bad, I think maybe I’m not good enough. Alana, PG2:Ln9}
\]

Louise, an experienced generalist nurse of Indian origin, expressed this view:

\[
\text{The handover we might not get everything and also one nurse we might not see again for one week. So many Agency nurses, must be difficult for them. We know all the problems of the patients in India, and also here they change patients. I think it’s not a good idea. If I get the same patients I know everything}
\]
about them and it’s easy for me to work with them. **Louise**, PG4:Ln10-11 & PG5:Ln1

Mei Li, a specialist nurse of Chinese origin, reported a problem with abbreviations:

> And, you know the abbreviations I find, its really difficult one abbreviation can mean lots of things. At hospital they have their own abbreviations. I get abbreviations book in shop and ‘internet’ you can download [sic]. Not much for nurses all for doctors. Sometimes the nurses use abbreviations. I don’t know how they can use lots of abbreviations in their progress notes. In the law in Australia they said in real documentation couldn’t use abbreviations [sic], nurses use abbreviations, very hard to read it. **Mei Li, PG6:Ln7**

Accents were problematic for both the non-English speaking nurses and local nurses in the clinical environment as the following comments show. However, in some cases the non-English speaking nurses perceived an improvement over the course of their studies, but still reported some difficulty with the use of abbreviations in the early stages. Jane, an experienced generalist nurse with extensive experience in India and Saudi Arabia, provided this comment:

> Actually not much problem, but in the beginning for some people their accent is difficult to follow. **Jane, PG2:Ln12**

> Actually at the end of seven weeks we are giving report to unit manager and it was clear and well understood. **Jane, PG3:Ln1**
However, despite some positive experiences there does appear to be some significant issues involved regarding patient safety, and legal requirements in relation to the use of abbreviations and the interpretation of medical orders in clinical practice.

Communication in health organisations, according to Thompson (1986), tends to be more complex than in other organisations because matters that are dealt with in health organisations tend to be more urgent than in other organisations. Most messages within the health care environment are in the form of orders and, unlike other organisations, there is no time to explain to the other person why the task has to be carried out quickly. In the case of NESB nurses this process is even more complex because of the language and cultural, professional, and environmental factors.

Nurses who were involved in the study conducted by Jones and Cheek (2003:123) recognised that communication permeated every interaction in nursing. This included every assessment and every intervention. Specifically, these authors reported that nurses noted that it was important to be able to ‘read’ people and situations, to be able to pick up on nonverbal cues and behaviours, and to work in an interdisciplinary manner. This requirement seemed to be problematic for the following participants:

_The handover, the language some wards they use words like they are in English they use slang and I think the patients like that also, with the patients it is difficult, also, I use normal English for the patient. The care of the patient is similar._

Angeline, PG10:Ln6

Similarly Mei Li, who is of Chinese origin, expressed this view:
The patients use slang language and we are not prepared for that because in our native language we don’t have formal language and informal language… it’s different and after one week we got better because you talk to patient [sic] all day every day. First week we only have to guess. Mei Li, PG12:Ln18

Some participants reported difficulty in communicating with patients whose first language was not English:

Some patients they understand sometimes they ask me to repeat again. Maybe difficult when the patient doesn’t speak English, but I try to communicate with a sign. Alana, PG3:Ln2

There was only one participant out of thirteen who reported that she found it relatively easy to communicate with patients in the Australian context. This nurse had worked outside of her country of origin prior to coming to Australia:

Really I found it most easy here and to tell [sic] to the patient also because when I was working Saudi there is a language also very different. In the beginning we have a lot of difference with the language also and they are not educated and it is very difficult. Here patients are better educated, in Saudi if you tell the patient this medication is for nausea or vomiting then we have to explain everything, but here we will tell and they know already. Jane, PG4:Ln1

As previously mentioned not all nurses who had previous professional experience outside of their countries of origin reported the same ease with communication with the patient population:
Some patients are Italian and most of them have different English and they cannot understand my accent. It is hard to communicate because most of them say their words differently. With English I think twenty five percent difficult. Leesa, PG6:Ln1

A further major concern for the NESB nurses related to communication was in the interpretation of medical orders. This issue will be discussed in the next section.

5.1.6 Interpretation of Medication Orders

The task of medication administration created anxiety for the nurses mainly for three reasons. Firstly, their perception of the inadequacy of theoretical preparation. Secondly, the system of prescribing; issues such as difficulty reading doctors handwriting in the clinical environment, and the lack of policy regarding the use of trade names and generic names in clinical practice was problematic. Finally, the implications of the first two points for patient safety and the legal protection of the nurse. One NESB nurse expressed concern with the reluctance of registered nurses to question orders with the medical officer if they experienced difficulty with interpretation of that order.

According to Deans (2005), medication administration is probably the highest risk task a nurse can perform and carries with it the potential to lead to devastating consequences for the patient and the nurse in the event of an error occurring. Deans points out that over the past ten years, medication errors are recognised as a significant cause of iatrogenic disease in hospital patients.
The interpretation of medication orders posed a significant problem for many NESB nurses with those who spoke on the issue, eleven out of fourteen, indicating that they experienced difficulties. The participants raised questions that could hold relevance not just for their own experiences within the system, but for many nurses in the context of the current fragmented nursing workforce where there is a heavy reliance on Agency staff and nurses who are employed on a casual basis in hospitals:

> I think the Health Department have to have a rule the doctor only allowed to write a specific name like the chemical name not brand name, because for nurse it’s very difficult and the other thing for doctor the poor handwriting, that can you know, [sic] if the doctor can write not rush write, but write bit better, so they can avoid lots of, you know incidents. You know, I don’t know why, the hospital don’t use the type [sic] for medication this is important for the hospital and for us the nurse. Mei Li, PG13:Ln3

It is suggested by Deans (2005) that the use of an electronic system of prescribing could substantially reduce the incidence of medication error. Although Deans did not report incidents of error as a direct result of misinterpretation of written orders, he did refer to the possibility that difficulties with interpreting the order could lead to a delay in administration of the drug (which can have undesirable effects in itself) due to the time spent in clarifying an unclear order. Another factor that emerged from Deans’ study was the confusion generated in relation to proprietary names of drugs. This concern was also raised in this study.

> It’s hard because they are using here mix of generic and brand unlike in our country we have a law, we…use generic [sic] all
prescriptions first, then brand names must be written in parenthesis. Leesa, PG5:Ln7

This participant also expressed concerns regarding the fact that she had noticed that nurses did not question the doctor’s order with the doctor if they had difficulty interpreting it:

They won’t ask they just guess or ask the other nurse. Mei Li, PG15:Ln1

Maybe they not feel difficult [sic] because they work with this doctor a long time maybe one year or ten years even, they know what he’s writing like. And, lots of nurses like Agency if they work day-by-day in different ward how they know. Mei Li, PG13:Ln4

Baker and Napthine (1994) found that cultural norms of a particular workplace and even the policy of the institution may conflict with the conscientious practice of nurses leaving them open to accusations of misconduct.

I asked Mei Li her thoughts about why that practice might be occurring:

First thing I think doctor difficult to find because they work private and public or they have own clinical [sic]. So first difficult to find doctor, the other thing is they think they know, they think they have this knowledge and they can guess. Other thing they have MIMS, they can check, but I don’t think this is safe to nurse. If they ask or check the MIMS maybe doctor means the other drug. Mei Li, PG15:Ln2
Baker and Napthine (1994) also found that medication errors were attributable in most cases to factors such as poor communication, abbreviations, culture of the particular environment, interpretation of medical orders, and the use of brand and generic names. This concern is not merely relevant to non-English speaking nurses at this time as indeed in this research many participants referred to the frequent use of Agency nurses and nurses who are employed on a part time and casual basis:

*So many Agency nurses, must be difficult for them.* Louise,

PG4:Ln 11

Deans (2005) noted that the safe administration of medications was not the sole responsibility of any one particular group of professionals, but moreover, that collaboration with other health professionals is central to the establishment of processes, policies, strategies and systems to reduce the occurrence of such errors. It is suggested by Deans (2005) that the use of an electronic system of prescribing could substantially reduce the incidence of medication error. In concurring with this view, it is suggested by the National Medication Chart Working Group (2004) that ensuring that hospital patients receive the best therapy in an accurate and safe manner is a complex process involving doctors, nurses, and pharmacists. It is suggested here that in the light of current trends in the international mobility of health professionals in general, and nurses in particular, an electronic system of prescribing is imperative in the interest of patient safety and to protect nurses from legal action.

### 5.1.7 The Legal Requirements

Nurses are bound by laws and codes of practice, in relation to their responsibility with regard to the supply, storage and use of drugs and preparations. These laws and codes are outlined in detail in the *Nurses Act*
1993 and the *Drugs, Poisons and Controlled Substances Act and Regulations* (Tisziani, 2006). In Australia, a drug or pharmaceutical preparation may be administered by a registered nurse only in response to a written or verbal order from a medical officer. The order must be clearly written and/or understood verbally. The law in all states in Australia requires that a legal drug order must be written in ink, dated and signed by the prescriber, and that if there is any doubt about the meaning of an order, the medical officer should be contacted for clarification (Tiziani, 2006). The nurse then has the right and in fact, a professional and legal obligation, to question doctors’ orders (Staunton and Chiarella, 2003) if for any reason the order is unclear. There are clear implications then from a legal and professional point of view for nurses in interpreting and questioning medical orders.

### 5.1.8 Impact of Travel

Some participants reported a significant degree of stress in relation to the impact of distance, in particular, from the clinical learning environment. Deanne, for example, travelled for at least three hours per day to get to and from the clinical venue:

> When I go to hospital it was very long way. We should have
> more choice of hospital we only had to choose from, because it's
> very far away from me. **Deanne, PG1:Ln2**

This is a similar concern to that reported by Shakya et al. (2000) in relation to international students in an undergraduate program who were granted exemptions from some subjects and therefore required to attend clinical placement whilst still very new to the Australian context. One respondent in that study had this to say:

> During my first clinical [placement], my problem was
> transport. I didn’t have a car and I didn’t know where the
station was. I know where the [train] station is but I didn’t know the route to go to the hospital. That’s the main problem. (Shakya et al., 2000:168)

I asked one of the clinical instructors if it was obvious in the clinical environment that participants were struggling with this issue:

*It can be a major problem, because often it seems as though accommodation is provided for them by the agent, but, it is not really close to the university and to where they have clinical placement. So they often have to get up at five o’clock in the morning for the early shift and late shift they get home late.*

Donna (Teacher), PG8:Ln2

### 5.3 Summary

The result of the data analysis has provided a view of the realities reported by the nurses in relation to teaching and learning in the CBAP. The main issues were associated with conditions of learning in the clinical environment. These concerns related to learning opportunities, and the nature of the tasks performed by Division One nurses. There were also reports of alienating behaviours such as reluctance on the part of Division One nurses to work with the NESB nurses to provide orientation and mentoring. Unreasonable expectations regarding the NESB nurses’ contextual and procedural knowledge also gave rise to concern. These behaviours impacted on learning opportunities in the learning environment through the lack of consultative processes and professional modelling available to the NESB nurses. Concerns also extended to the current system of prescribing medications in terms of patient safety and the legal implications for registered nurses.
Chapter 6

Adaptation

6.1 ADAPTATION

This chapter provides accounts of a range of issues that impact on the adaptive processes for NESB nurses both culturally and professionally. Issues that facilitate and hinder those processes are explored and discussed with a view to developing strategies to facilitate the contextualisation of existing skills for this group, and the development of context-specific skills through productive learning experiences. It is suggested that such a focus could reduce professional wastage through the employment of the nurses in areas that are clinically inappropriate in the light of their previous professional education and experience.

It is posited by Young (1988) that the successful adaptation of strangers is achieved only when their internal communication systems sufficiently overlap with those of the native people. This enables them to develop ways of seeing, hearing, understanding and responding appropriately to their new environment. As many of the NESB nurses involved in this study had just arrived in Australia, it is unlikely for most of them that they would have acquired the cultural overlap described by Young (1988).

The degree of cultural adaptation and language development that NESB nurses require depends to a great extent on their country of origin, previous exposure to Western culture, previous postings outside their country of origin, as well as professional, interpersonal, intra-personal and environmental factors. This accounts for the variations in the degrees of difficulty experienced in the learning environments, particularly the clinical environment.
6.1.1 Professional Adaptation

Adaptation to a new area of practice creates significant problems for non-English speaking nurses because the process is complicated by cultural, linguistic, policy and legal issues. Competency Based Assessment Programs provide a better alternative to what Hawthorn (2001) described as the ‘hit or miss’ assessment that prevailed in the late 1980s. Nevertheless, nurses still experience considerable challenges to their professional identity related to the context, scope of practice, and the professional knowledge base necessary to practice in Australia in terms of the health care system and legal frameworks.

Issues associated with adaptive processes fell into nine areas as revealed through the analysis of the data. These areas were:

1. Systems of care delivery
2. The impact of frequent change in patient allocation
3. Disempowerment
4. Inadequate orientation
5. Discriminatory practices and professional isolation
6. Staff expectation
7. Communication as it impacts on the professional relationship and the exigencies of practice
8. Perception of skill level following registration
9. Concerns regarding employment following registration

There are several examples that have emerged from this research that reflect the ways in which the issues above, and their associated challenges, impacted on professional adaptation. These challenges can lead to skill wastage and segmentation in the clinical workforce (Hawthorn 2001; Kingma, 2006). Skill wastage and workforce segmentation can arise from two interrelated factors: a lack of educational support in the workforce during the transition phase,
and discriminatory attitudes of employers and colleagues (Hawthorn, 2001). Each of the above issues and their impact on adaptation will be discussed below.

6.1.2 Systems of Care Delivery

Twelve out of thirteen of NESB nurses indicated that they were accustomed to functional (task allocation) system of care delivery and one person did not offer comment. This contrasted sharply with the patient allocation system commonly used in Melbourne based hospitals. The same system of task allocation, or functional nursing, prevailed in Australia until relatively recently when it was replaced by a system of total patient care (Walsh, 2002). In the latter system, where one nurse is allocated to care for a given number of patients, it is still possible for fragmented, task-centred care to occur, although the system was introduced to help create a more holistic approach to care delivery (Walsh, 2002). However, the system is criticised on the basis that it requires a high level of registered nurse Division One nursing hours, making it more costly, and the level of Division One nurse intensity may not be warranted in many cases (Kelly-Heidenthal, 2004).

The patient allocation system was viewed positively by some NESB nurses in this study. Some offered comparative comments but did not provide a value judgement. Others were critical of the content of workload allocated to the registered nurse, such as the difficulties associated with finding time to deliver aspects of patient care that they regarded as being more important and in line with their responsibilities, than basic care. Aspects of patient care that were considered more important related to physical assessment, ongoing observation, evaluation of the patients’ condition and liaison with medical staff. Some of the positive responses regarding the patient allocation system
are shown in this example which was provided by a inexperienced generalist nurse of Indian origin:

> Just five patients in the morning and that’s good. If I need help I will ask from by buddy. But the nurses help each other. It is very nice. Nanette, PG2:Ln10-11

However, there was also a range of criticisms regarding the system of care delivery. Some related to the amount of paperwork associated with care delivery. Others were associated with the heavy nature of the work and the associated difficulties, with one nurse being required to deliver care that required physical help to patients without adequate assistance.

An experienced generalist nurse of Eastern European origin indicated that despite the fact that she had fewer patients to care for here, there seemed to be less time available because of more paperwork and a more friendly approach to interaction with patients:

> I don’t know why I’m so busy here with only three patients. I used to have thirty patients in my country and still have time to read the notes. In my country ratio of patients varies up to thirty-three patients, but on the other hand they have more paperwork [here] and more sort of friendly. Deanne, P5:Ln2-3

The issue of paperwork is a point that has been raised by scholars of nursing who pointed to the fact that one system of nursing documentation that accompanied the care delivery system change, namely the nursing process, generated a vast amount of paper work with which many nurses are unhappy (Walsh, 2000; Walsh and Ford, 1992).
The next comment was from a nurse at a different clinical venue. Mei Li previously worked as theatre nurse in China. She expressed concern regarding the heavy physical nature of the work associated with the patient allocation system:

*Why can’t we have two nurses work together, patients too heavy for one nurse.* Mei Li, PG10:Ln24

Gray (1995) commented that the Australian way of providing nursing care, with a nurse working alone and asking for help only as a last resort, has implications for the nurse in terms of occupational health and safety and places the nurse at risk in terms of back injury. It is also suggested that it poses a risk to patient safety because of the reliance on one nurse to provide physical assistance. Gray (1995) suggests that, although the patient allocation model has a great deal to offer, it would be wise to consider ways of combining the system with the team concept.

The team system works by assigning staff to teams that are responsible for a group of patients. Each team is lead by a registered nurse. Care is divided up and allocated to the most appropriate care provider in accordance with the skill level of the particular staff member (Kelly-Heidenthal, 2004; O’Connell et al., 2006). A criticism of this model according to Walsh (2002) and Kelly-Heidenthal (2004) is that it leads to fragmented care. However, it appears from the comments that have been put forward by participants of this study that care delivery seems to be fragmented with the patient allocation model because of insufficient numbers of Division One registered nurses in the current system.

A teacher was asked about the impact on the NESB nurses of working in a different system of patient allocation and she was of the belief that the
overseas nurses were more accustomed to having an overall perspective on all the patients in their care rather than having to concentrate on a small number in great detail:

A lot of them are used to caring for forty patients and to say to them you’ve got to look after four they think they can rush through the care but when you ask them what is the patient’s blood pressure and when they are going home, I think it’s a bit of a shock to them. They have to know these four patients in detail.

Gail (Teacher), PG3:Ln7

It should also be remembered that in the case of NESB nurses, it is their first exposure to applying their professional skills in Australia and that the hands-on care of the patient is not the only issue occupying their minds at any given time. The system in which they operate is complex with a myriad of subsystems, including, but not limited to, various forms of documentation, various policy initiatives, professional relationships, learning needs, linguistic, cultural, environmental and geographical challenges all of which add to the complexity of the encounter. Therefore any issues arising in this context with its inherent complexities are not amenable to simple explanations and solutions.

In an effort to understand the layers within the system that created problems for the non-English speaking nurses, teachers were asked how the NESB nurses coped with the nursing process and various types of documentation in the clinical environment:

Documentation, they seem to be quite used to writing nursing notes, care plans they don’t quite so good, certainly not the academic type like we get them to do here and it goes back to the medical management of the patient and forget the personal bits.
And, that could also go back to because they are not used to looking after the person the family do that. Donna (Teacher), PG10:Ln2

Another teacher also commented on the academic nursing care plan (this is a document utilised as a learning tool, designed by academic staff to systematise the students’ approach to patient assessment and care) and seemed to think that it actually helped the nurses to focus their thoughts in relation to patient assessment:

The other document they have is the Nursing Care Plan that they do each week and that takes time to develop and maybe it’s the uni terminology it’s confusing for them at first. That’s the tool that they use it does help me and them, and they have to go back to the books and compare that with the care that is actually given at the bedside. It has helped a lot with the students. Leanne (Teacher), PG3:Ln4-5

It seems that this piece of documentation used as a learning tool can help the NESB nurses to think about the delivery of care in a slightly different and perhaps more holistic way than the medically focused systems to which they are accustomed. In fact the nursing process and the associated nursing care plan was initially developed as a tool for teaching care planning (Walsh, 2002). Nonetheless, this is not to say that losing sight of the medically focused system is, in all ways, positive given the close proximity to the medical model in which nurses practice by virtue of the care they deliver in institutionalised and community-based systems. A further complicating factor reported by NESB nurses was the frequent change of patient allocation which is discussed in the following section.
6.1.3 Impact of Frequent Change of Patient Allocation

From the analysis of data it appears that non-English speaking nurses’, in addition to the host of professional and environmental challenges described in the previous section, were also faced with the difficulties associated with frequent changes in patient allocation. It was evident from the data analysis that clinical teachers’ expectations of the NESB nurses performance is strongly linked to, and influenced by, the duration and structure of the CBAP program and the care delivery system in which the NESB nurses will practice following professional registration. It would also appear that teachers are cognisant of the fact that many of the nurses rely on agents to facilitate their access to the workforce and thus encourage the nurses to operate in a way that facilitates that process. One teacher explained:

They need to be taking a four patient load because one day they will be out there doing it on their own. **Leanne (Teacher), PG4:Ln2**

Of the six out of thirteen participants who commented on this issue, all were critical of the practice of frequently changing patient allocation. As the following comment reveals:

*I would like to have the same patients for two or three days. Get to know them, sometimes not [sic] time to look at histories. It’s very important to know what you are doing and the patients’ conditions [sic]. Also depends if you know hospital routine and you can manage your time and what’s appropriate to do. Once you get used to the hospital you can decide what to do and what’s priority now.* **Deanne, PG2:Ln4**

The issue was also raised by NESB nurses who were placed at another clinical venue and cited it as being a professional issue:
Here an amazing professional problem they are always changing the staff. I mean the nurses are changing. Today the nurse has 1-5 & 7, tomorrow a different nurse. I had an experience today, because yesterday I had a nurse who was very experienced and the patient was very cooperative yesterday. And, today it is new graduate and the patient is very aggressive and she doesn’t want to do anything, very difficult. We don’t know much about our patients, stay for a few days better [sic]. Angeline, PG:8 Ln7

Here they change patients. I think it’s not a good idea. If I get the same patients I know everything about them and it’s easy for me to work with them. Louise, PG4:Ln11& PG5:Ln1

It would appear from these comments that the nurses are not unrealistic in their expectations regarding the number of days they would like to remain with the same group of patients. According to Bjornsdottir (1998) it is important for a nurse to be able to develop a trusting relationship with patients. Some of the respondents in her own study reported this as a factor that made nursing meaningful work for them as the following comment from Bjornsdottir’s (1998) study reveals:

I enjoy nursing most when I know my people, the patients I’m working with. This happens when I’ve been working for a few days and know them well enough to feel secure. At such times I’ve started to get a response from them and they get a response from me. (Bjornsdottir, 1998:355)

A similar case is made by Jones and Cheek (2003) in relation to an Australian based study where nurses revealed that knowing the person (the patient), knowing the network, knowing the context, and being able to pull everything
together was an important part of their practice. The nurses in the Jones and Cheek study revealed that knowing the person involved spending time with people and spending time in the environment. They regarded assessment as the lynchpin for their practice, as did NESB nurses in this study. However, in both cases it was indicated that assessment involved contextually dependent knowledge. Such contextually dependent knowledge is extremely difficult for the NESB nurse to acquire given the constant change of patient allocation and the fact that most are already struggling with cultural, linguistic, professional and environmental challenges.

Yet, despite the views of the NESB nurses on this system of patient allocation Gail, a teacher, expressed the view that the nurses needed to adapt to the system because of their reliance on agents to find them professional employment following registration. That would mean that they would work in a different health care facility each day and would therefore not have an opportunity to read patients’ records in detail prior to caring for them. Gail was asked if the practice could be considered a hindrance to their adaptation to the system:

\[
\text{Not really, a lot of them will try and get the same patients each day and I find that annoying because they are just emulating what they see everyone else do. So I explain to them you will be working Agency because you’ve signed a contract, so you won’t have time to read up on them the night before you will have to work that into your shift. Gail (Teacher), PG5: Ln.2}
\]

Gail was asked if two days would be a reasonable time frame to provide an opportunity for the NESB nurses to read histories:
That’s OK in the beginning say first week, but not after that especially when a lot of them will be working Agency. Gail (Teacher), PG5: Ln.2

From the point of view of a professional educator and an experienced nurse it is difficult to understand how this practice provides a more appropriate learning opportunity than repeated exposure to the same patient population given the multiplicity of professional and environmental factors to which the NESB nurses are required to adapt. Instead it would seem that, as Deanne (mentioned above) pointed out, familiarity with the environment makes it easier to decide what is a priority.

The issue of brief periods of clinical exposure has been addressed (NRNE 2002), in relation to undergraduate education, with support for longer periods of clinical placement in one venue being preferred over a succession of short-term placements. This is ostensibly in order to improve learning opportunities for students and to provide teachers and preceptors with the opportunity to address students’ learning needs and assessment criteria. The same broad principle applies to teaching and learning in the case of the non-English speaking nurse population, although there are vast variations in their existing skill and knowledge base.

6.1.4 Disempowerment

The clinical learning environment is a multidimensional entity that according to Chan (2001) has a direct impact on the outcomes of clinical education for students. Non-English speaking nurses reported considerable challenges to their professional identity related to the context, scope, and the professional knowledge base necessary to practice in Australia. Feelings of disempowerment related to a number of issues in practice including
language, abbreviations, and cultural differences, as well as practice and policy issues. It is noted in recent studies (Johnson and Preston, 2001; MacIntosh, 2003; Mayben et al., 2006) that new nurses often find their workplace experiences challenge their ability to enact their professional ideals. In commenting on the socialisation processes as experienced by newly qualified nurses, MacIntosh noted that they experience considerable stress during the first year of practice.

The non-English speaking nurse is also likely to experience a considerable level of stress associated with the need to adapt to the culture of the clinical environment in relation to procedures, policies, patient needs, and challenging clinical situations (Kilstoff and Baker, 2006). In addition they are at times challenged by the loss of professional autonomy and power.

Seven nurses out of thirteen spoke about their attempts to find their own identity in professional practice. They experienced various levels of frustration with being beginners in practice and the associated lack of autonomy. Nurses from various cultural and professional backgrounds reported similar issues. Deanne who was of Eastern European origin and an experienced generalist nurse provided these comments:

_I’m still trying to find my own way because I’m still so much with the buddy nurse and the clinical educators as well. Sometimes you think it’s not right and you get the feeling as a nurse that you would do that different, but still haven’t got your registration so…._ Deanne, PG4:Ln 6

_The big challenge, you have to overcome a few things like the beginner in practice, and the attitudes of some staff, they are not very friendly it’s not very nice. You have to study all the time, if_
you skip something it is difficult, at the end of each day you have
to divide your work, each day you have to do something. Deanne,
PG1: Ln3

The concerns expressed here seemed to relate to issues with interacting with
staff and concern with the expectations of staff as Kilstoff and Baker (2006)
reported with the NESB undergraduate and postgraduate population of
NESB students of nursing.

In addition to the anxiety produced through coping with processes of
socialisation and care delivery in the clinical learning environment, Chan
(2001) points out that the reactions of nursing staff to the efforts of the learner
are a significant cause of anxiety during the clinical practicum. In relation to
this issue an experienced generalist nurse from the Philippines made this
comment:

It’s hard to exercise what you know, and what you have learned,
because we don’t have the authority or the power to do [sic].
Leesa, PG1:Ln2

This nurse, a specialist of Indian origin with eleven years experience in an
intensive care unit, expressed this concern:

Experience I had in my own country. Here it is different if I
work on a ward once I get registration I may not be able to go
through the whole medicines what is the use of that, because I
work in a different area. Angeline, PG11:Ln 1

Benner (1984) points out that there are particular challenges associated with
the transfer of concepts across clinical contexts and notes effective clinicians
are aware that context is a crucial moderator in nursing practice. The
comments above indicate that the NESB nurses have made that observation and proceed mindfully in their new environment despite the fact that many of them found themselves in areas of practice that were vastly different both in terms of clinical speciality and the system in which they have previously practised. Yet, they adopt an analytical approach to modifying their nursing actions, contextualising their skills, and developing new skills in the clinical environment. This to a certain extent requires focused attention to theory and rules of practice (Dreyfus and Dreyfus 1977 as cited in Benner, 1984) in the current environment and a linking of those rules and rituals to their previous experience in order to make sense of their current learning situation.

The context of the workplace, therefore, is influential in the development of nurses as autonomous professionals. The components of the workplace climate that support nurses include team-work, acceptance, a sense of personal importance, the freedom to ask questions, and good fellowship (MacIntosh, 2003). There were many instances where NESB nurses reported less than optimal responses from staff as NESB nurses and teachers reported in this study; responses that, in many instances, pointed to unreasonable expectations on the part of hospital staff.

6.1.5 Staff Expectations

Closely linked to the concept of disempowerment is the issue of staff expectation. These expectations may, in part at least, be grounded in what Barnum (cited in Benner et al., 1996) describes as pre-conceived notions of what it means to be a graduate of an accredited school. Benner et al. (1996), in tracing the skill development trajectory, supported the view that there is no one specific set of characteristics or professional ability that is attributable to all nurses. Benner further points out that there are particular challenges associated with the transfer of concepts across clinical contexts and notes that
context is a crucial moderator in nursing practice. This is particularly so in the case of non-English speaking nurses in the light of the diverse range of cultural, professional, educational, and linguistic backgrounds to be found amongst that group.

According to Sanchez et al. (2005), learning to cope in a foreign environment involves a profound personal transformation that almost parallels the process of human development throughout the lifespan. The implications of this for the individual are that the coping responses developed in one’s previous work and social life may prove counterproductive in the new environment. The sudden loss of control that results from culture shock can abruptly disrupt the individual’s equilibrium and can lead to an imbalance between the individual and the environment that fits the definition of stress which in turn threatens wellbeing (Sanchez et al., 2005).

However, as will be seen from the following excerpts from the NESB nurses’ responses, expectation in the clinical environment seemed to indicate rigid levels of expectation on the part of clinical nurses which stemmed from the fact that they had been informed that the NESB nurses had been previously qualified in their country of origin. In the clinical context then, there seemed to be little attention, if any, paid to the acquisition of contextual skills. This process refers to the development of knowledge of how to get things done in a particular social context (Eraut, 1999).

In referring to the number of Australian qualified nurses who leave the profession in their first year of practice, Johnson and Preston (2001) note that the phenomenon is strongly related the expectations of their first employer. Typically, according to these authors, major hospitals expect them to “hit the ground running” and to be adept at all the requirements expected of an
experienced ward or theatre nurse. In an exercise of thoughtful comparison
Johnson and Preston point out that no other profession expects the newly
qualified professional to be so adept. These authors point out that a new
engineer for example is not called upon to design a major bridge or
steelworks. The fact that the new nurse whether an overseas-qualified nurse
from a non-English speaking background or a new ‘home grown’ graduate is
expected to demonstrate proficiency in all things clinical is, according to
Johnson and Preston (2001), possibly a hang-over from the days of hospital
training. In that case, nurses spent three years at their training hospital and
upon achieving nurse registration were adept at the skills needed in that
particular hospital. The current university-based system provides nurses with
a greater depth of understanding of health care and therefore on the job skills
need to be perfected in the individual clinical environment (Johnson and
Preston, 2001). Conversely, Billett (2001) argues that there is long standing
evidence that people learn their vocations quite successfully through work,
and indeed have developed understanding and robust transferability of skill,
creativity, and functionality. Non-English speaking nurses have already
acquired a particular level of skill and functionality whether they are a
graduate of a hospital or a tertiary-based program (and there were both
involved in this study). They need an opportunity to apply their existing
knowledge and skills and to develop new more contextually appropriate
levels of functionality.

Ten participants out of thirteen spoke on the issue of staff expectations and, of
those, seven spoke negatively and three reported positive experiences in
terms of help obtained from clinical ward staff:

Sometimes they ask you how long you been working as a nurse.
They make you feel, you know, like you are nothing. It doesn’t
give you confidence. Deanne, PG2:Ln6
They say you are qualified nurse you have to know that. If I know why I am here [sic] Mei Li, PG3:Ln1

The following comment is from Leesa, an experienced generalist nurse from the Philippines:

One time a nurse she remembered I told her I was working for ten years and she was watching me how I do [sic] preparation of an IV (Intravenous) medication and I was very nervous because she was watching me, and you know the thing but you get lost in some way, you are mistaken because you are very nervous and because you are nervous the more you are prone to mistakes, and she told me, how come you are very nervous since you have been working for ten years. And, I was struck, and it was like a slap in my face when she told me that, and for me it was really rude and straight forward. That is why we are so cautious in every thing we do we have to please every one because we are aware that we have evaluation. Leesa, PG1:Ln5

It is pointed out by Xu et al. (2005) that all behaviours in the presence of another person are communication. These authors go on to say that Asian people favour an indirect style of communication because directness is considered threatening and rude as is evidenced by the above account provided by a nurse from the Philippines. Whilst this explanation possibly sheds light on the cultural aspect of the encounter for the Asian nurse, it does not explain the lack of understanding regarding the context dependent nature of nursing work on the part of the registered nurse who made the comments.

Wickett and McCutcheon (2001) point out that it is unrealistic to expect that nursing practice is similar all over the world. Instead, they argue that nursing
experience and nurse education reflect the needs of the community served. The comments provided by the nurses here in relation to attitudes in the clinical environment do not seem to reflect any understanding of this viewpoint on the part of clinical nurses, as this comment would seem to reflect:

*Sometimes I don’t know if it’s appropriate to ask questions they might think that I’m silly. They make you feel like you are nothing. It doesn’t give you confidence. I’m trying to do my best and do those things, but you ask all the time. They make you feel less than they are because they are working here for a few years they think that they are better.* **Deanne, PG 2:Ln6**

This generalist nurse, who was of South American origin, had been out of professional practice for over ten years and reported what she perceived as a negative attitude on the part of a member of the nursing staff at one clinical venue:

*Can’t remember in three weeks like someone ten years there. I feel really bad when going to give Heparin, when I was about to give[sic] she just took it from my hand in front of the patient and did it herself and said we have to do it quickly.* **Alana, PG5:Ln 1**

This comment seems to epitomise the view of Benner (1984) that in order to advance skill learned in the classroom, a nurse needs situational experience. Benner goes on to say that any nurse entering a clinical setting where she or he has not had experience with the patient population may be limited to the novice level of performance if the goals and tools of patient care are unfamiliar. It was suggested by some NESB nurses that a period of orientation would be valuable in terms of improving learning opportunities.
6.1.6 Orientation

Orientation to the clinical environment was deemed to be a very important factor in the process of adaptation during the nurses’ period of study. The significance of this process was also noted as being important to the undergraduate nurse population on the basis that short placements in multiple health care environments do not result in worthwhile clinical education experiences (Heath, 2002). This is equally important for the non-English speaking nurse as indicated by the following comments. All thirteen non-English speaking nurses indicated that environmental orientation was important to them in terms of enabling them to provide care, utilise and contextualise their existing knowledge and skills, and acquire new knowledge and skills:

*It should take time maybe up to one week so we understand Australian hospital. First week should be orientation with observation let us understand what the Australian nurse really doing [sic] in the clinical, not just leave us to do it.* Mei Li, PG5:Ln8-9

It would seem from the next comment that valuable learning time is wasted with the nurse walking about the ward to pass the time when she could be actively and usefully engaged in care delivery and clinical learning:

*Not enough orientation…we just have one hour of orientation and I’m on orthopaedic we have to shower patient I just want to know what the routine.* Mei Li, PG9:Ln1

This nurse stated that not knowing what to do next caused her to be anxious, and that sometimes she just walks around because she doesn’t know what to do next:
Don’t know what to do next routine. The patient say why you walk so much, sometimes I feel lost. Mei Li, PG9:Ln12-13 (Field notes, brown notebook)

In a more neutral tone Angeline, a specialist nurse of Indian origin, provided this comment:

*The course it is good but when we come to the hospital I want more orientation to the ward, the procedures we know, but the policies are different.* Angeline, PG7:Ln8

According to Edmond (2001) the knowing “when” and “how” is learned through integration and application of propositional knowledge and repeated experience in interpreting practice situations, responding appropriately and reflecting on feedback. Logically, Edmond claims, this can only take place in the social context of the practice setting.

The importance of adequate orientation when the nurses were required to have a ward and or venue change was also a concern for teachers:

*When I did the clinical part they had to move three times. I think that was too much. They need a reasonable amount of time to settle into a ward and get to know the ward culture...I think they really need four or five weeks to settle in. I think there’s a reasonable argument if you think that it’s not so much the nurse having problems with skill then give them an opportunity in a different area can be quite beneficial for them. You do get personality clashes.* Donna (Teacher), PG5:Ln1.

Donna expressed concern with regard to the need for students to swap clinical venues part way through their clinical exposure and how she believed the move impacted on the students’ learning and assessment. The need to
swap clinical venues is deemed to be more disruptive than a mere ward change within the same clinical venue, although both impact on adjustment processes and consequently learning opportunities.

At the administrative level the need to change venues relates directly to the limited availability of appropriate clinical placements. If it is not possible to get the requisite range of experience at one acute care clinical venue then the non-English speaking nurses are, on occasions, placed in subacute areas for part of the clinical education component. This necessitates a move approximately half way through the clinical component, a move that both nurses and teachers find disruptive to learning and adaptation as this teacher reported:

I certainly think that clinical is long enough, it’s a little bit hard because we swap our students after four weeks which is not long for them to pick up on behaviours they need to change...which means that you have got a very, very fast curriculum, which means that what they do in the first week you must put up for review, which makes it very, very hard on the student, so I'd like to see them having one clinical [placement]. Gail (Teacher), PG5:Ln1

There are two issues that emerged from the data above. Firstly, the need for adequate orientation to, and inclusion in, the clinical environment. And secondly, the need for productive partnerships between health care providers and universities. The latter is important in order to facilitate clinical placement without the necessity to move students part way through the clinical component of the program. In addition, it would help to avoid the hardship of excessive travel and the personal dangers and expense associated with that for NESB nurses.
It would seem from the comments provided by both NESB nurses and their teachers that the quality and consistency of the clinical exposure is a factor that needs to be considered in relation to the expectations placed upon the NESB nurse. This has relevance in terms of the duration of the program, in other words, issues of quality as well as quantity are of equal importance. This makes it important to improve partnerships with health care providers.

**6.1.7 Partnerships with Health Care Providers**

Partnerships with health care providers have been the subject of concern for academics (Gabb and Keating, 2005) and policy makers alike (Johnson and Preston, 2001; NRNE, 2002). Organised clinical placement is recognised as the most challenging component of pre-registration nurse education (Clare et al., 2002). It is suggested that many of the challenges associated with this are organisational and financial and indeed reform to the funding model has been suggested (NRNE 2002). Judging from the comments regarding the necessity to change venues part way through the program and the incidents of unreasonable expectation reported by the NESB nurses it is difficult to believe that any major improvements have occurred in the system to date.

**6.1.8 Discrimination and Isolation**

Non-English speaking nurses reported some examples of what they perceived to be discriminatory behaviours toward them by nurses in the clinical environment and the discomfort associated with those behaviours in terms of learning and adaptation. This issue also emerged in the findings of Amaro et al. (2006) in a study of recently graduated nurses from NESB which investigated ethnically diverse nursing students’ perceptions of educational barriers, as well as the findings of Dreachslin et al. (2000) on communication effectiveness in nursing care teams.
In this study of those who spoke about the problem, five out of nine people reported feeling upset by perceived incidents of discrimination and exclusion in the clinical environment; four people reported that they accepted the fact that they did not feel included; and two people believed that they were included. The remaining four did not comment.

The following comments represent the extremes reported by the non-English speaking nurses:

> Here I found some staff really rude, discriminating because I come from the Philippines they are looking at you from head to toe, sometimes they are challenging you if you can do [sic] what they are doing. Sometimes if you are asking them to help they will say why don’t you look for your clinical instructor. Leesa, P3:Ln1

The impact of culture cannot be ignored in this nurse’s perception of people looking at her from head to toe given that in Philippino and other Asian cultures direct eye contact is viewed as a lack of respect (Covington, 2001). However, there is other evidence from non-English speaking nurses and their teachers to support the view that varying degrees of discrimination, in fact complicated by various forms of aggression, actually exist in clinical environments:

> Sometimes staff are not very professional, swearing in front of patients, making faces behind your back. And, it’s sad that the patient tells you about the nurse’s behaviour, and it wasn’t just my patient there was two patients, ‘cos, they ask [sic] me afterwards, did you find it difficult to work with those people? and I said, Oh sometimes…
“We saw (patients words reported by the NESB nurse) the nurses in the nurses’ station and they were making faces behind your back” which is not really professional. Deanne, PG 2:Ln5

The fact that this was observed by patients and conveyed to the nurse makes it not only a matter of discrimination in the workplace, but also an issue of professional image and conduct in the light of customer focus, not to mention the current emphases on improving the image of nursing (Buchan and Calman, 2005). According to these observers, image must also reflect the reality, and indeed the comments from the NESB nurse in question do not reflect a reality that many would care to venture into. It is also important to note that this behaviour violates the Code of Professional Conduct and the ANMC Competency Standards (ANMC, 2005). Behaviours of this nature could also be identified as aggression and are frequently directed at new nurses and students because, according to Leiper (2005), they become easy targets for aggressors. It is recognised that aggression, sometimes referred to as horizontal violence, thrives in nursing. This is a factor that is not only recognised nationally (Deans, 1999; Farrell and Gray, 1996; Farrell, Bobrowski and Bobrowski, 2006 and Jones, 2006); but, also internationally see for example (Buchan and Calman, 2005; Kelly, 2006) as a factor that impacts on retention of nurses in the health workforce.

To some extent the view that aggression is frequently direct toward new members and students (Jones, 2006; and Leiper, 2005) is borne out here with some participants indicating that they could accept feelings of isolation because they were new and some believed that it would stop when they graduated. One nurse who had graduated indicated that she believed that it would stop when she gained more experience and did not need to ask as many questions:
Maybe I think they’re not nice because I ask so many questions,
but when I improve I expect it will stop. Lei, PG13:Ln4

A clinical teacher who supervised and assessed some of these respondents
and had worked with overseas nurses undertaking competency based
assessment for a number of years reported that she observed behaviours that
she personally viewed as discriminatory or exclusionist in nature:

It’s limiting communication with the student (NESB nurse).
Well absence of any social communication. Sometimes, it’s
limiting professional communication…it’s the tone it’s the eye
contact. You know two nurses will be having a social
conversation and one of the students will come up because I’ve
asked them to report an abnormal BSL (Blood sugar level) and
they’ll leave the student waiting there, not talking to them until
they are ready to address them and that is very, very demeaning
to a thirty or forty year old woman and the grad might me
twenty one or twenty two. Gail (Teacher), PG6:Ln1

Another teacher who spoke on the issue seemed to convey a similar
perception of a particular behavioural response on the part of staff:

Not enough that I would go to a charge nurse and say this is
blatant discrimination, but going back to what we were talking
about language accents and the students making themselves
understood, some staff will be much more tolerant of what the
nurse is saying whereas others will be very dismissive. Donna
(Teacher), PG6:Ln3

However the third teacher reported that she did not believe that there were
any problems with discrimination:
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Not really a lot of them are very ethnic so they could relate to these nurses, so it was good that the staff were understanding.

Leanne (Teacher), PG1:Ln6

Nonetheless, she did indicate that despite the broad ethnic mix at that particular hospital there was at least one exception to her previous statement:

Actually there was one unit manager who was...(I have purposely withheld the nationality of the unit manager mentioned here for confidentiality reasons), and he would just ignore the student, he would just wipe her off with a wave of his hand and wouldn’t communicate with her, there was another student I put on there and she was from China and he didn’t have any problems with her maybe because she was from an Asian background. Leanne (Teacher), PG2:Ln1

These responses provide a comparison and to some extent a contrast, yet both seem to indicate that there are behaviours exhibited that are less than professional, could be perceived as racist, and lead to a degree of discomfort for all concerned. It is understandable then that non-English speaking nurses experience stress, anxiety and discomfort in relation to this issue.

Delahaye (2005) seems to concur with the views of Hawthorn (2001) and Kingma (2005) in referring to the energy expended by the non-traditional worker in just trying to fit in, and warns of the waste of precious human resources in organisations that are not inclusive. In addition, Delahaye points out the risks of potential costs associated with claims under the Equal Opportunities Act (E0).
It is argued by Delahaye that the EO approach has not been as successful as was originally expected, although it is claimed that the approach has made some advances in combating dehumanising practices in the workplace. The shortcoming, according to Delahaye, relates to the reliance on external legal forces. It is argued that a better approach would be the management of diversity which is about trying to get it right for everyone.

It would certainly seem from the accounts provided by participants above that alienating and dehumanising practices are alive and well in some clinical environments and that despite more than two decades of increasing emphases on provision of services to culturally diverse health consumer groups, little has changed in terms of how nurses from culturally diverse backgrounds are treated in the clinical environment.

### 6.1.9 Speciality Areas

One of the challenges faced by NESB nurses is the requirement to practice in a clinical area that is significantly different from that to which they are accustomed in terms of the nature of the medical conditions treated in a particular area, and the knowledge and skill base required to practice in that area. It is noted by Benner (1984) that any nurse entering a clinical setting where she or he has no experience with the patient population may be limited to the novice level of performance if the goals and tools of patient care are unfamiliar. This became most apparent during the time spent observing NESB nurses in the clinical learning environment and it seemed to compound their anxiety in relation to contextualising their existing skills and building confidence in their professional abilities.

Of the thirteen non-English speaking nurses that were interviewed, all reported some concerns regarding the impact of working in a different area of
practice. Seven participants expressed more serious concerns than the others. Those who practised in speciality areas such as operating room were more likely to report more serious concerns regarding the adjustment process, whilst those with a broad range of experience in a variety of clinical areas and in more than one country reporting more positive perceptions of the adjustment task. Non-English speaking nurses who had been absent from clinical practice for a number of years also seemed less confident than those with more up to date experience in practice. During an observation this nurse who was from an Eastern European country told me:

*Changed unit this week this is a busy medical unit. I don’t like medical ward, I never worked in medical before everything is so different. I don’t know why I am so busy here with only three patients. I used to have thirty patients in my country and still have time to read the notes.* Deanne, PG5:Ln1-4 (Field Notes)

Two days later she told me:

*I don’t like this as much as the last unit, surgery, more action there, like my previous experience. I like action.* Deanne, PG5:Ln19-20

This nurse was observed for five days in the clinical environment. The observation sessions took place at different times of the day and on different shifts. Visits were always unannounced, and it was noticed that she worked by herself most of the time. The observation took place on the medical ward she referred to above. It was noted that one time in particular when she was extremely busy she told me:

*Sor**y I don’t have time to talk we are behind so I have to work very fast* (Deanne PG5:Ln28-29Field Notes)
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The following day it was observed that she was working by herself again. Different section today I inquired:

“I did not even get my lunch yesterday. Oh I hate this place”.

Deanne, PG5:Ln 30-31 (Field Notes Entry Dated)

Similarly this Chinese nurse who had also been observed for five days in the clinical environment reported during a field observation:

I hate medical ward it is like a nursing home shower, shower, shower, I never worked in a medical ward before I like surgical I like to be really, really busy. Mei Li, PG11:Ln26-27

Only five more days to go ...I want to work in surgery and I want to do post graduate study, so that I can specialise, I think it’s better to specialise. Mei Li, PG11:Ln31-32 (Field notes: entry dated)

Mei Li was asked if she believed that her existing skills as a specialist theatre nurse were being utilised and if those skills would continue to be utilised following registration:

This is hard to say; first I am a theatre nurse I don’t usually work on the wards and I learn [sic] nurse practice skills a long time ago, basic knowledge is there, I can understand, I think for short time practice I can do. Mei Li, PG8:Ln10

A specialist nurse who was of Indian origin and had worked in a transplant intensive care unit expressed concern regarding how she would cope with working on a general ward following registration. Her concern was mainly related to the belief that staff were not allocated according to their level of expertise:
I think always according to the experience the staff should be rostered then it will be very easy for the staff and the patient to get the care from them. Angeline, PG10 Ln6 & PG11: Ln1

Angeline asked if this was her experience in her current clinical placement:

Rarely, so I was thinking when I’ve finished my course to do an ICU course because it is difficult for me in transplant ICU. Angeline, PG10: Ln6 & PG11: Ln2.

Another nurse of Chinese origin, who was also observed in the clinical environment and who had a professional background in paediatric nursing, reported:

I like working here I have never worked in surgical ward before I came to this country and the agency tell me [sic] I work in surgical ward when I finish, also maybe in nursing home. I never work in nursing home I am paediatric nurse. Lei (Field notes PG13: Ln12-18: Brown notebook: Entry dated)

When Lei was asked following completion of the program if she would return to paediatric nursing she replied:

No, at this stage I don’t want to work in paediatrics because I used to talk with my agent and [sic] they told me unless you do special training. Lei, PG14: Ln1

It is not clear if it is in fact necessary for the nurse to undertake further training in paediatrics. However, it is not unreasonable to suggest that this experienced nurse should have an opportunity to demonstrate her skills in the area of paediatric nursing with appropriate supervision and mentoring. It would seem that being required to work in a clinical area in which she has
less expertise would pose a greater risk to patient safety in terms of her knowledge base and the application of theory to practice.

This scenario seems to bear a strong resemblance to what Johnston and Stewart (2003) refer to as the unethical practice of exploiting or misleading overseas nurses by encouraging them to accept job responsibilities that are incompatible with their professional experience.

By contrast however, some NESB nurses did come from similar clinical backgrounds and seemed to perceive fewer problems associated with the transfer and contextualisation of skills. It will be seen from the comments in the next section that some believe that their existing expertise will enable them to adapt even in a different clinical environment albeit one that involves varying degrees of anxiety and frustration. Jane is of Indian origin and had a diverse range of clinical practice experience in a senior role both in India and in Saudi Arabia. She talked freely about her previous experience and seemed proud of her accomplishments in her career so far:

\[
\text{In the beginning it was a fifty-two bed medical ward we have patients with general surgery and seven neurological patients, mostly accidents who are coming in and they have craniotomy.} \\
\text{Immediately before coming to Australia: I worked one year in medical ward in India and before that I worked in primary health in Saudi Arabia. Jane, PG2:Ln2-3}
\]

Leesa is an experienced generalist nurse from the Philippines who reported that she had ten years post registration experience in a variety of clinical settings including emergency department and operating room. Leesa reported that she perceived communication issues and feelings of strangeness to be a greater deterrent to her adjustment than clinical practice in itself.
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The hands on thing the nursing skills I can practice at the same level, but still [sic] with communication. I think I can function 75% but still 25% with communication and adapting to the environment. I am a stranger in this place, something that worries me. Leesa, PG10:Ln2

It was revealed that younger nurses who had less postgraduate experience seemed to express less concern regarding their ability to adapt to professional practice in Australia. For example, Elaine from India indicated that she had worked for one year post registration’ said that it would be relatively easy for her to apply her skills in the Australian context:

I think I will be able to work here, before I was a bit worried, but it is all the same how you care for the patient. I think I will be experienced. Elaine, PG4:Ln3-4

Elaine was asked what kind of skills she believed she should have in order to consider herself experienced:

To take total care of the patient, and do the work that is allocated for us, so I can do the whole care for the patient’s procedures and communication. Elaine, PG4:Ln3-4

It seemed that the total number of years of professional experience did not necessarily mean that the nurse was more confident, in fact in some cases it seemed that adjustment to a different area of practice was more difficult for those who regarded themselves as specialists in areas such as operating room, paediatric, and intensive care nursing. An example of this is provided in this comment from Mei Li who is an experienced operating room nurse from China:
They only give us general ward and you know some nurse [sic] are specialised in their country and I know there are some paediatric nurse, or theatre nurse or mental health nurse and they are only doing the general wards after that they apply for specialised job, like me theatre nurse. Actually I was anxious because I don’t know what will happen when I go on the job. So maybe we can change a bit and give a specialised clinical practice. Mei Li, PG18:Ln8

6.1.10 Concepts of Beginning Level of Skill and the Need for Supervision

Closely related to issues associated with adjusting to professional practice in a different clinical area, and cultural context, is the issue of the nurses’ perceptions of their own level of skill and the need for ongoing support and supervision following registration.

Fourteen nurses were interviewed (including the “Discriminant Case”) at various stages during the program and I conducted follow up interviews with five NESB nurses within approximately one month of completion of the program. At that time one person had commenced employment with a nurses’ agency, five were seeking employment, and one had not commenced the process at the time of the last interview. One of those, Jane’ was not interviewed during her period of enrolment, but rather asked to recall her experiences following completion of the program and prior to commencing employment. This was in order to compare her perceptions to those of other NESB nurses with less clinical experience prior to commencing the program.

Participants, including those interviewed following completion of the program, reported various perceptions in relation to how they would perform in Australia immediately following professional registration. The issues that
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featured most prominently were medication administration, culture shock and language difficulties; and to a lesser extent, technology, other staff and environmental concerns. A sample of excerpts from those that were interviewed following completion of the course will be provided first in this section. These are participants Alana, Lei, Deanne, Leesa, and, Jane.

Of the thirteen non-English speaking nurses that were interviewed all except one indicated directly or indirectly that they would need varying degrees of support and supervision following registration. This nurse was of South American origin and had been absent from professional practice for over ten years prior to undertaking the program. She indicated that whilst she would not need direct supervision, she would need support with new procedures:

*I think not supervision... maybe support with things I have not done before. Pump; (Volumetric device used to regulate intravenous infusion) when I first go to hospital I feel afraid,[sic] don’t like machine, now not that afraid.* Alana, PG3:Ln9-10

*Big difference here from my country, here nurses work more freely and identify needs.* Alana, PG5:Ln4

*I think the telephone is the worst, yes it is always more difficult.* Alana PG3:Ln4

A nurse who had just commenced casual employment following completion of the program provided the following example of her experience with adjustment in the clinical environment:

*Oh it’s hard sometimes, sometimes I think there is a lot I need to learn, but sometimes I find my experience is quite helpful.*
Sometimes I don’t know what it is, but from my experience I can understand how to do it. I think from my experience I can do.

Lei, PG8:Ln9

Lei was asked how she would describe the difference in her clinical performance in terms of expertise at that point compared to her performance in her own country:

I think all the things are not very serious. Yesterday I work in ...hospital and the problem for me is they put all the medications together not in the patient’s drawer, so I have to find some medications in another drawer, so because I’m not familiar with all the procedure I don’t know where they put all the medications and some have more than two names, so I can’t find so I just ask them. I think when we always ask it make them unhappy. Lei, PG13:Ln8

Deanne, a nurse of Eastern European background, was asked what she viewed as the greatest set of barriers preventing her from practising at the same level that she did in her country of origin:

The biggest barrier the other staff and equipment still worried about that. Deanne, PG7:Ln6

It is probably not unreasonable to suggest that all of these nurses require varying degrees of organisational support in the early stages of transition to professional practice in Australia. This relates to the risks associated with medication administration in an unfamiliar context, as well as linguistic and environmental factors competing for the nurses’ mental energy. It suggested by Sanchez et al..(2000) that learning to manage in a foreign environment involves a profound personal transformation that in his view has an analogue
in the process of human development throughout the life span. However, it is possible that not all foreign workers experience the same degree of cultural disorientation. It is suggested by Schlossberg (1981) that this will depend on the degree of difference between the previous experience and the new situation. Nonetheless, learning to cope with environmental factors such as culture, language, professional relationships, and work practices was reported as a source of stress for most NESB nurses. It is important to remember here that stress and competing demands on the nurses’ time was viewed as one of the major factors contributing to medication errors in Deans’ (2005) study. This once again points to the need for policy driven systems to support these nurses during their transition to practice in the Australian context, as this comment highlights:

*I’m still confused about how they admit patients, how they discharge patients…The paperwork, the routine, where they are going to send these papers.* **Leesa, P4:Ln1-3**

Another issue of concern related to Leesa’s ability to function as a registered nurse was:

*Maybe how you contact the doctor, if you have to ring a doctor about a patient. I’m worried about the communication through a phone because it is different if you’re communicating in person,*

*it concerns me.*

*The relationships I think we came from different cultures maybe that would be…* **Leesa, PG8:Ln6-7**

This nurse of Indian origin, who was placed at a different clinical venue, expressed a similar view:

*I’m not confident about my language, for my patient care and procedures for that I think I am quite alright, but for some*
other...like the nurse say the patient is discharged and she come & take all the documentation and we are taking care of the patient and we did not know about that and I don’t know how she knows. When we come to the nurses’ station to see the file there is nothing there about that. Angeline, PG9:Ln1

In this case it seems that there was a breakdown in verbal and written communication which seemed to engender a sense of hopelessness. It is noted by Sanchez et al. (2000) that adjusting to an international assignment can produce a sense of helplessness in the individual who may have difficulty working out what is appropriate and what is inappropriate in the professional sphere.

Lei was asked what she considered to be the most difficult thing in terms of coping in the hospital:

I think culture shock. Lei, PG12:Ln11

In Australia people like to talk about the sport, not the family relationship. We are not sure what we can talk about with the patient, in Australia communication important, in China not important, here the nurse talk more to patient. In China one nurse twenty patients, no time to talk to them. Lei, PG13:Ln1

The “Discriminant Case” explained what she viewed as the greatest barrier to her own prospects of practising professionally as a Division One nurse following completion of the program:

The isolation of four patients… also depends on who is on, like some people will say do you want a hand. May be too scared to
ask because people might think you are incompetent, and also my knowledge. Susan (“Discriminant Case”), PG5:Ln2

It would seem from this comment that this re-entry nurse experienced a considerable amount of anxiety relating to her return to professional practice. This is something that perhaps needs further investigation in the light of the fact that nursing organisations seem to believe that convincing non-practising nurses to return to the profession is one way of addressing the shortage of nurses (Armstrong, 2004). It also raises concerns regarding the clinical environment in terms of how non-English speaking nurses cope given that an English-speaking nurse has expressed such concerns.

6.1.11 Problem Solving Skills

In an attempt to further explicate the nurses’ perceptions of their beginning level of skill, questions were asked regarding how they felt about their decision making capacity, their thoughts about the importance of physical assessment, and their perceptions of how competently they carried out various levels of clinical assessment in practice.

Walsh (2002) emphasises the importance of clinical assessment as the basis for planning nursing care and evaluating therapeutic responses and points out its utility in underpinning the traditional planning approach in the nursing process and the newer critical pathway. All thirteen non-English speaking nurses provided an account of how they would carry out a physical assessment of a patient:

According to the assessment we take care of the patient and the treatment and how we decide for them. Hailey, PG4:Ln6

Similarly this nurse reported having recent acute care experience:
I did my assessment and that was alright for me in India. I go through reports and I know if sodium is low or potassium is low so immediately I ring the doctor… Here I never had a chance like that to do [sic]. Angeline, PG9:Ln 3

And, this experienced paediatric nurse from China:

Yea, I think I can do it good: Colour, pulse, percussion and auscultate [sic]. Take the baseline and then check to see of the patient have [sic] shortness of breath, colour is pale, pulse weak or quite fast that sort of thing. Lei, PG9:Ln1-2

These comments are typical of those provided by the NESB nurses in relation to the physical assessment of patients. However, this Chinese nurse expressed concern regarding the fact that her ability to assess and monitor her patients’ condition was impacted upon by being frequently called away to help other nurses with hygiene related tasks:

If I have more time I think I can have more information about my patient, diagnosis and medication and what do you do about the patient, and ask nurses or doctors about the patient...if you not give hand to other patient for hygiene [sic] and obs. (observations) then more time. Lee Lin, PG6:Ln12-13 & PG7:Ln1

This is another example of the limitations placed on the nurses’ learning opportunities by the demands of helping other nurses and being merely used as pairs of hands rather than supernumerary learners in the clinical environment.

In the case of the overseas nurse then, the nurse may well have had prior experience in the clinical situation they encounter in terms of the biomedical
dimension, but be inhibited by political, legal, linguistic, and contextual factors including patient characteristics that could lead to limited application of skill. The latter could be the case for many non-English speaking nurses as they enter the new clinical environment as is reflected in some of the feelings of frustration and disempowerment that nurses reported in relation to their learning and practice experiences. In addition, the fact that these nurses are rarely allocated to a clinical area that is a close match to their prior professional experience seems to exacerbate the problem of knowledge and skill application and development. Two clinical teachers were also interviewed following completion of the program and commented on the issue of skill application as follows:

I feel that because of the rushed time I am not committed to saying this person can get out there and work on their own because they have been working under supervision and it’s a limited time, that is not good enough to say they can get out there and work on their own. I would say they are out there to the level of a graduate nurse most of them. Leanne (Teacher), PG4:Ln3

However, this teacher expressed a slightly different view:

I think it’s long enough to be able to make an assessment of: can this nurse work in this country at that particular level and I think if they can’t demonstrate that within twelve weeks then they certainly need support education. Sometimes the problems are not necessarily knowledge problems e.g. one nurse who’s work here (the university) was quite good, but out on clinical she would just stand there with a vacant look on her face, she couldn’t cope with the practical aspects, a lot…had to do with
communication problems. So you can say yes they’re OK or no they’re not. Donna (Teacher), PG2:Ln3

It is argued here that the skill base of the non-English speaking nurse cannot be reliably compared to that of the new graduate in the Australian context, unless of course the nurse has been newly qualified in their country of origin. For most other nurses a period of time in a clinical environment that is closely matched to their existing skill base and with adequate support, mentoring and professional development with a built in system of appraisal would go a long way toward maximising their contribution to the delivery of nursing care in the Australian context. This would also provide an opportunity to become socialised into the formal and informal norms of practice in Australia. Indeed this kind of exposure is regarded as paramount even for the undergraduate nurse (Benner, 1996; Clare et al., 2003). The amount of time cannot be reliably predicted, as so much would depend on contextual, professional, interpersonal and intrapersonal factors in the practice environment.

6.1.12 Perceptions of Clinical Decision-Making

Some nurses expressed concerns and a sense of uncertainty regarding independent clinical decision making in practice. Ten NESB nurses were asked how they would regard their own capacity to make clinical decisions in the clinical environment following registration. In doing so it was hoped to gain insight into the extent to which nurses would need support and mentoring in the clinical practice arena following registration since the purpose of this research is to inform policy.

Out of the ten people who commented, six indicated that they felt reasonably confident about their clinical decision-making, two were very doubtful and
two were not at all confident. The following responses represent the extremes and some in-between perceptions regarding the nurses’ decision making capabilities following registration.

Following completion of the program a nurse form the Philippines believed that if she needed collaboration to make a decision it may be more difficult than if she had to reach a decision herself:

*Decision making, maybe if you need collaboration it will affect,*

*but if the decision is an independent action I think it won’t.*

Leesa, PG9:Ln1

From an analytical point of view it seemed that what Leesa was saying is that if it were possible for her to make a clinical decision herself then that would not be a problem. However, she believed that if she needed to collaborate with other health professionals such as a doctor then that would complicate the issue.

An experienced intensive care nurse from India indicated that, if she had made an assessment of a patient and thought that the patient’s physical condition had deteriorated she would:

*I would discuss that with the doctor about the condition of the patient. I need somebody, example medical team.* Elaine,

PG6:Ln9-10

At the other extreme, a nurse from South America who had a lengthy break in her professional practice prior to undertaking the program reported:

*Actually to make decisions more confident now than when I started. I have more knowledge, I feel confident. So afraid when I started with the names of the meds and now had [sic]*
opportunity to study a bit more secure and confident and I can make decisions and assess the patient. You have to make decision to what you are going to do to improve the patient’s health.

Alana, PG7:Ln2

Similarly, an experienced generalist nurse who had a diverse range of experience in India and Saudi Arabia believed that picking up small changes in the patients’ condition would not be any more difficult in Australia despite the cultural differences:

No because if there is a change we will report in the nursing progress notes then according to that we have to observe the patient and report to doctor or unit manager. Say if the patient is febrile…then we have to plan the nursing care according to that. If there is breathing difficulty we would have to start some oxygen therapy. Jane, PG5:Ln8,9,10,11

Again there were mixed responses from participants regarding their decision-making capabilities following registration and certainly some evidence to suggest that the nurses are sufficiently aware of the necessity to make clinical judgements and the implications of such judgements and the appropriate consultative processes. In commenting on a study conducted with NESB nurses undertaking postgraduate studies in Australia, Kilstoff and Baker (2006) noted that some of the respondents in her own study found the level of clinical decision making, and subsequent level of responsibility required of nurses in Australia, unsettling and contributed to their need for closer supervision. There were elements of such a concern also evident from this study as will become clear in the next section.
6.1.13 Perception of the Level of Professional Responsibility in Australia

Eleven participants out of thirteen were asked about their perceptions of the level of professional responsibility in Australia, and ten commented. Five believed that nurses had more responsibility in Australia and five thought the level of responsibility was the same despite the differences in nurse:patient ratios and different operating systems. The following comments reflect typical opinions. This Chinese nurse believed that there was more responsibility:

More responsibility here… in Australia if you look after patient [sic] you have to know all about the patients what the patient needs, patient want. Mei Li, PG8:Ln9

Angeline, an Indian nurse, expressed a similar view:

More, the nurse can take ECG (Electrocardiograph) if any bradycardia or anything the nurse can take the decision. Angeline, PG4:Ln6

The following comments were from a nurse of South American origin:

About the same, here we have just five patients, in my country one to forty, but the responsibility the same. Alana PG3:Ln10

We don’t give them showers, we don’t feed them, dress them and [sic] shaving the patient, we have other things to do more important. We do priorities for our patients if we see the patient is not improving we have to do something else another action. Alana PG8:Ln2

Similarly, an experienced nurse from the Philippines:
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It’s the same, the responsibility is the same, you have to look everything, you have to assess your patient and report to the doctor or the charge nurse, it’s the same here. Leesa, PG6:Ln6

A Chinese nurse expressed a similar concern regarding her ability to practice:

Yes, I will know the difference between China and here, but in unfamiliar environment even in China will need time to adjust. I have practised here in … if I get a job in another hospital I [sic] also need time for me to adjust. I know what I have to prepare for before I go to next hospital especially the medicine. Getting more confident about medicine. Lee Lin, PG8:Ln6-7

It is likely that differences in perception regarding the level of responsibility related to the nurses’ previous experience and area of clinical practice. Some, for example, may have been accustomed to working in more low-key clinical areas than they first encountered in Australia. In other cases however, the nurse had worked in a specialised area such as an operating room or intensive care. What is important to observe is the insightful critique and comments that nurses applied to various aspects of their learning experiences and norms of practice in the clinical environment in particular. This reflects a degree of professional insight that one is highly unlikely to encounter in a new graduate.

A teacher was asked if she believed that the NESB nurses were realistic in their perceptions of what kind of clinical area they could cope with following registration:

I think a few are a little bit adventurous in the type of jobs they apply for. We also get some who come in and a week before they start the course they have been working in intensive care in
Saudi or somewhere. I think those who have done that sort of thing are fairly aware of their abilities and what they can do, the ones I’d have more problems with are the ones who have been out of nursing for a while local … who haven’t nursed for a while, some of those almost need a graduate year to consolidate their learning, but most of them are fairly realistic. Donna, (Teacher), PG10:Ln4

6.1.14 Issues with Competency Assessment

Competence in clinical performance is guided by and assessed in accordance with the ANMC National Competency Standards for the Registered Nurse (ANMC, 2005). Data analysis revealed a number of issues associated with the assessment of competency in the clinical practice environment. Firstly, some nurses were not aware of the Competency Assessment tool and were not clear about how they would be assessed and in fact what the teacher would was looking for. Teachers also spoke about the current system of appraisal and what sets the assessment process for these nurses apart from the undergraduate population generally. Some of the comments put forward pointed to the issues for teachers with establishing the level of practice the nurses were accustomed to in their countries of origin and in other countries in which they practised. I asked three teachers about the challenges and rewards of working with these groups of nurses.

I think the hardest thing is getting to know the nurse as a person
I can’t make a true assessment until I know them as a person.

Leanne (Teacher), PG2:Ln3

This teacher was asked if knowing the nurse as a person meant knowing their professional values:
Knowing they are coming through a difficult time to get here. I know that’s an important issue in their life to be accepted here in Australia, that is already clear to me. Just their background is not clear to me, what is their idea of nursing. I don’t know what kind of background they have, it could be a nurse from Russia and she might have done clinical practice in a community centre. I don’t know how much she can contribute to clinical on a ward, so I need to know that person’s experience as well and how much they value being there. I know they want to be a nurse in the end, but are they going to be able to communicate and appreciate the other staff and their patient as a person, that needs to come across to me fairly clearly, if they’re going to be accepting the situation they’re in. Leanne (Teacher), PG2:Ln4

Leanne was asked how difficult it was for her to do all of this in a few short weeks and to work out if the person is competent to practise as a Division One nurse at the end of that period:

I have to keep close communication with them in the beginning.
I also keep close communication with the staff to see how they think the student is doing and the feedback is important although it can be biased and I have to beware of that as well, but generally across the board if I get good feedback or negative feedback, I take that into consideration where it’s relevant. I also keep account of who they are working with, what kind of nurses and what their expectations are of the student. Leanne (Teacher), PG2:Ln5

Another teacher was asked how the experience of teaching and assessing non-English speaking nurses differed from the undergraduate population. This
teacher pointed to the vast differences in backgrounds and recency of practice, and spoke of issues not altogether unlike the previous person:

*There are two groups. Those who come from the Middle East and they may well have been working up to just before, so therefore they have already got current practice…whereas local ones are refresher or else they are in some ways refresher because they have been in the country for quite some time but haven’t been able to register because of their language skills. So two different groups, so you have to redevelop their clinical skills as well and the same for both groups you’ve got to change their understanding, give them the perspective of what it is like to nurse in Australia, it’s often very different from where they came from e.g. the Indians they tell me they do the technical work but they don’t shower the patients, so that’s a bit of a culture shock for them.* Donna (Teacher), PG1:Ln1

The same teacher reported that the factors in the clinical situation that would impact most on accurate clinical assessment are:

*One is the time you get to spend with them, the opportunity to observe them doing, whether the opportunities are there and available on a particular ward.* Donna (Teacher), P11:Ln2

This teacher was asked to comment on the adequacy of the current assessment tool in terms of the assessment of NESB nurses’ competence:

*Do you want to get me started on that; I think the Domains from the ANMC are quite good areas to look at. There are a few areas that I think are fairly iffy. I don’t think...these kind of students get a chance to demonstrate...because they are more for qualified nurses that’s one of the problems with the ANMC*
Standards. It’s my understanding that they were developed for qualified nurses. Donna (Teacher), PG11:Ln2

The third teacher reported similar differences in relation to the experience of teaching and assessing these groups:

Their experience and age, very different approach, need to listen a lot to their stories. They may have ten years experience in intensive care unit (ICU) or dialysis. The overseas people have a different reason to be here as distinct from the undergraduate. With international registered nurses they really want to become nurses, like they have a lot of knowledge, so a lot of it is just becoming familiar with the drugs, in their country they have a different name, a different legal system. A lot of times it’s combating resistance, what they know versus what they need to know. Gail (Teacher), PG1:Ln1

This teacher was also asked about the usefulness of the current assessment framework and again the person reported not liking the tool although these two teachers were from different universities and would therefore have used an assessment tool that is different in structure, but nonetheless designed to assess the same competencies:

I don’t particularly like that tool. It is very, very wordy without being clear. I think it needs to more pragmatic, because a lot of these people have the knowledge it’s just you know becoming familiar with the IMED pumps; a lot of it is technically based. Gail (Teacher), PG2:Ln6
6.1.15 Concerns Regarding Employment Following Registration

Participants expressed varying degrees of concern regarding their ability to secure employment following registration. Three people reported having serious concern, five people expressed some reservations, and one person seemed confident that she would secure employment. The remaining five participants did not comment. Concerns in relation to this matter are important because of the fact that they compete for the nurses’ attention during their period of intensive study.

The following comments reflect the nurses’ thoughts on the issue. At one extreme this Chinese nurse expressed uncertainty because of the fact that she and some of her colleagues were relying on an agency to assist them to find employment, but on the other hand she was hopeful on the basis that there is a shortage of nurses in Australia:

It’s hard for me to know because we are relying on agency to come here, so we will be agency nurse. Lei, PG8:Ln6

I understand that Australia have [sic] shortage of nurse and here I will have a lot of opportunity and I want to learn more at university. I’m planning for that ICU (Intensive Care Unit) course. Lei, PG8:Ln8

I want to be the best nurse in Australia, because I’m the best nurse in China. Lei, PG15:Ln1

An Indian nurse expressed this concern:

I heard it is very easy to get a job. But when I came here I saw colleagues and they still have not got a job and they are having
so much suffering and the money is almost gone and I am anxious about that. Angeline, PG6:Ln14

This response is surprising given the current shortage of qualified nurses in Australia. However, Omeri and Atkins (2002) reported similar findings amongst graduate nurses of NESB backgrounds.

At the end of an interview session a nurse of Indian origin was asked if there were any issues that we hadn’t talked about that she believed were important to nurses from overseas, and she identified one:

*It is very difficult to get a job because if we want to get a job they have to sponsor us.* Hailey, PG6:Ln1

Two factors of concern emerged here: level of confidence to perform as a Division One nurse, and concern with securing employment following registration. It is ironic that these concerns should exist in a time when, by all accounts, there is a critical shortage of registered nurses in Australia. It is also of some concern that, apart from skills and language assessment policies and processes, there is no central policy driven initiative in place to assist these nurses to gain appropriate employment where their existing skills are fully utilised and where they are assisted in the contextualisation and further development of those skills. An initiative of this kind could prove helpful to both NESB nurses and prospective employers.

At the other extreme however, one nurse seemed much more confident about her employment prospects and her perceived level of confidence. She was a nurse of Indian origin with many years experience at the clinical management level outside of her country of origin. Her experience included community-
based health programs and hospital-based acute care. I asked her if she had any concerns about practising as a Division One nurse in Australia:

*After graduation I am planning to start a job. I think seven weeks of clinical practice it will help me to work in Australian hospital, because before when I started the course I didn’t know anything about the policies and procedures.* Jane, PG1:Ln10

The responses from participants in this area seem to point to two issues of uncertainty regarding availability of employment and their perceived need for supervision in clinical practice immediately following professional registration. In the light of the expectations regarding employment arrangements during that phase, in terms of reliance on agency-based casual employment, it seems that a policy driven framework to assist these nurses to secure employment and to provide support during a phase of adaptation to a new environment would be of benefit. Some indicated that they wished to undertake further study in Australia.

### 6.2 Summary

Multiple factors impacted on professional socialisation and adaptation in the clinical environment. These factors in turn impacted on the application of existing skills and the acquisition of contextual knowledge and skills. Years of experience and existing level of skill, including linguistic competence appeared to have no bearing on the degree of alienation reported by NESB nurses. These concerns seemed to be related more to the clinical workforce culture that operated at particular clinical venues, than to the cultural, professional, and linguistic competence of a given individual.

It is argued that improved clinical partnerships with health care providers could reduce or eliminate the necessity for NESB nurses to move from one
clinical venue to another during the course of their re-training and therefore reduce the difficulties associated with competency assessment and the transfer of concepts across clinical contexts (Benner et al. 1996).
CHAPTER 7

EXPERIENCING DIVERSITY
7.1 Diversity

Diversity was a strong theme that emerged from the data analysis. This is because the NESB nurses frequently spoke of differences in relation to the patient population and the nurses with whom they worked. Diversity seemed to pose challenges both in relation to interaction with the clinical workforce and with the culturally diverse nature of the patient population. This chapter will explain the non-English speaking nurses’ perceptions of the cultural diversity experience, particularly in the clinical learning environment.

It is suggested by Ting-Toomey (1999) that the primary dimensions of diversity shape and mould the individuals’ self-image and directs thinking, feelings, and behaviour. This is described by Loden and Rosener (1991) as “otherness”; those human qualities that are different from our own and outside the groups to which we belong. Others then, according to these authors, are those who are different in one or more dimensions.

Loden and Rosener suggest that there are two sets of dimensions that contribute to the ways groups of people differ from one another. Firstly, there are the primary dimensions that include human differences that are inborn and impact on early socialisation, having a significant impact throughout life. These include, but are not limited to, ethnicity and culture. The second set of dimensions of diversity relate to conditions that can be changed more easily. These are what these authors refer to as differences that are acquired and can be discarded and modified throughout life; for example, educational level and professional experience.

In the case of the NESB nurses who were involved in this study, both sets of dimensions were significant, as most had recently arrived in Australia from a range of culturally and linguistically diverse backgrounds.
It is pointed out by Cortis (2003:55) that the world view of a group gives rise to the culture of that group, and therefore the culture of the health care system. Covington (2001) expressed a similar view, stating that the health care system is a culture in itself with core values that are predicated on a world-view that is linear, scientific, sequential, competitive, and power orientated. These values according to Covington (2001) emphasise mastery, independence, logic, future orientation, and individual achievement.

In contrast however, those from ethnically diverse backgrounds may espouse values that are related to social connectedness, interconnectedness, interdependence and present orientation (Covington, 2001:99). Covington suggests that these values are likely to be manifested in the way individuals approach team-work and problem solving as well as differences in accents and non-verbal communication. These factors make interaction unpredictable and can produce feelings of emotional vulnerability and threat for the newcomer and existing personnel alike.

The work of Cope and Kalantzis (1997: 16) provides a useful framework in which to view the concept of diversity in the health care workforce. They suggest that productive diversity focuses on the dynamic relationship of difference in the establishment of common ground. These authors suggest that workforces are most effective when they are as diverse as the environments in which the organisation is situated. However, Davidhizar, Dowd and Ginger (1999) note that the hospital workforce diversity, instead of being regarded as a potential source of creativity and improved problem solving, can often be a source of political strife and mistreatment of people. These authors suggest that such organisational pathologies are often associated with unmanaged workforce diversity.
In this research the NESB nurses provided accounts of what they found to be most challenging in the clinical environment. It is possible that their views have the potential to enrich staff education programs, with the ultimate aim being to maximise the identification and utilisation of the specialist and generalist skills of the NESB nurse population.

According to Ting-Toomey (1999) encountering a dissimilar other helps us to question our routine way of thinking and behaving. However, in this case there seems to be a lack of willingness on the part of local nurses to understand and respect those differences. This is depicted in statements like this provided by Leesa, who was an experienced generalist nurse from the Philippines:

There are some staff who are very warm and helpful, but there are also some staff who are bullying 50% are good and nice and warm, 50% are raising their eyebrows, looking [sic] you from head to toe. They don’t say it straight forward but you can feel it. I am a stranger in this place, something that worries me.

Leesa, PG9:Ln9&P10:Ln2&3

The words and phrases used to describe behaviours in the clinical environment such as ‘good’, ‘nice’ and ‘very warm’ seem to reflect what Covington (2001) refers to as a belief system that respects and values social interconnectedness.

It is suggested by Omeri et al. (2003) that hospital staff can also experience difficulties in the cross-cultural encounter and that it is important for them to have the opportunity to discuss issues and develop mechanisms to promote student and staff satisfaction. Lei, a specialist nurse from China, was asked if she were to talk to a group of staff, what would she tell them regarding her
feelings, experiences and educational needs. Lei’s response to this question was as follows:

This is a hard question because we never try to communicate with staff only when we do the clinical practice. So first we will tell them about our overseas experience and which area we have worked in China because when you go to the ward first question is are you student, next are you a Division Two. I told them we are Division One so they couldn’t [sic] believe that.  

Lei, PG14:Ln11

Lei was asked if she thought that the staff accepted her as a professional:

She laughed: Sometimes they don’t treat us like professional [sic] person. I think just have to treat us like professional person, especially the older nurses.  

Lei, PG15:Ln3

Spouse (2000) highlights the importance of feeling accepted in the clinical environment as a major factor in professional adaptation, and it is suggested here that it also impacts significantly on one’s ability to learn and contribute. According to Beagin (2001), in order to be accepted in an unfamiliar setting it is necessary to engage at a deep level with the professional mores of the new community. This level of engagement seemed to be problematic for NESB nurses as is evident from their accounts of learning, in particular, in the clinical environment.

In the absence of appropriate education regarding the influence of culture in relation to how people view the world, assess situations, make decisions, communicate, and generally behave, ethnocentrism is likely to persist in the workplace. It then becomes difficult for staff to appreciate the challenges
encountered by NESB nurses as their behaviours and abilities are interpreted according to the rules and values of the local population.

According to Thiederman (1991:23), ethnocentrism or cultural projection refers to the unconscious process by which people tend to evaluate everything according to what they know. The assumption is that the behaviours of others, regardless of their country of origin, can be interpreted according to the rules and values of one’s own culture and that everybody’s actions arise from identical motivations. Ethnocentrism however, according to Thiederman, is a natural part of the human condition to the extent that all people are accustomed to particular ways of thinking since birth that are shaped by institutions, systems and values of a particular society. It is suggested by Cortis (2003:57) that observing the behaviours of others through one’s own values and belief systems is like looking through a screen. However, Cortis suggests that whilst it may not be possible to remove it, knowing that it is there allows for a more insightful interpretation of behaviour.

It is not intended to criticise the tendency to prefer one’s own culture, nor is it suggested that people ought to abandon their own culture. In fact, quite the contrary. It is suggested by Thiederman (1991) and Chew (1999) that in order to understand other cultures it is important to know one’s own. It is also important to remember that the NESB nurse will also engage in cultural projection as their own culture is likely to be their only point of cultural reference.

It would be highly impractical to expect that staff could learn all the specific behaviours that characterise all of the cultures that are encountered in the health care workforce. However, it is suggested by Yoder (2001) that
approaches to education need to recognise that culturally diverse learners operate from deeply and culturally defined systems of values, beliefs and meanings. In this research, teachers suggested two approaches that could assist the NESB nurses with the adjustment process, one of these was staff education and the other was confidence building through positive feedback.

7.1.1 Staff education

Teachers indicated that staff at the clinical level needed education in relation to the learning needs and cultural differences encountered amongst the non-English speaking nurses. One teacher indicated that this could be very difficult because staff at times claimed that they were not aware that the students were expected at the clinical venue:

*I think definitely the staff [need] education, but that’s difficult because sometimes I turn up and people will say that they didn’t know the students were coming.* Gail (Teacher), P7:Ln3

All three teachers who were involved in the study were asked to identify information that they believed would be important to convey to hospital staff regarding the non-English speaking nurses learning and socialisation needs if they were involved in staff in-service in that area:

*A lot is with their culture and again it’s not culture it’s personality as well, different personalities. Some of them are very shy and I might think this person is incompetent because of her personality and politeness.* Leanne (Teacher), PG5:Ln6

Another teacher, Donna, made a similar observation in relation to some cultural groups:

*The Chinese, Indians and other Asians tend to be very quiet, they sit there in class and [it is] difficult to get them to talk, they*
are not very giving with their knowledge. Donna (Teacher),

PG1:Ln4

Gorman (1999) also commented on the impact of shyness as a poorly understood trait in relation to the assessment of competence in the undergraduate student nurse population of non-English speaking background. This possibly relates to the fact that some behaviours associated with social connectedness and interdependence (Covington, 2001:100) are at times viewed as non-assertive, emotional, dependent on others, and lacking leadership skills (Gorman, 1999).

It is suggested by Thiederman (1991:5) that the only way to distinguish between culture and personality is to observe the attitudes and behaviours of other people who belong to the same ethnic background as the person in question. If the same behaviour is found among others of the same group then according to Thiederman, it is likely to be cultural. The important issue here, however, is that there seems to be an appropriate awareness of this on the part of teachers as evidenced by the comment above and this comment from Gail:

A lot of them come from countries where they have a strict hierarchy so they are very, very quiet. Gail (Teacher), PG5:Ln4

I’d probably include in there that all these students [NESB nurses] have passed English so there is no question about whether they can speak English because they can, it is just a matter of their communication. I’d let them know that communication is a problem, but it really is people not speaking to them clearly…people using slang words. I’d tell them a lot of these students bring a good ten years experience with them and they are really adding to our nursing pool; and on the wards it
tends to be a lot of young and inexperienced nurses and who would you like to work with someone who’s got ten to fifteen years experience in CCU/ICU or a grad who is just straight out of uni. Gail (Teacher), PG5:Ln4

A similar response was provided by Leanne, another teacher, regarding what she would tell ward staff regarding the non-English speaking nurses’ learning needs:

They would probably ask me what is their experience, can they speak English, and what their goals and what responsibility will they have while they’re here. Leanne (Teacher), PG6:Ln5.

This teacher was asked to summarise in a few sentences how she would address these questions:

OK, they do speak English, but they have an accent and the staff language will also be strange to the student [NESB nurse]. So time to adjust will be required, giving them time to express themselves, that will take time and encouraging them to speak up. By the end of their placement they would have to be able to care for four patients and their skill level [would have to be] as a Division One with procedures and medications. Leanne (Teacher), PG7:Ln1

7.1.2 Confidence Building

The following are some comments from clinical instructors regarding how confidence building helped the NESB nurses to adjust:

They became very confident with some positive feedback from the staff and towards the end some of them could complete the
tasks on their own for that shift without supervision. Leanne (Teacher), PG1:Ln6

Building their confidence will certainly help with their communication.

Gail (Teacher), PG5Ln4.

7.1.3 Positive Learning Experiences

Non-English speaking nurses also spoke of some positive experiences that they believed helped them to become familiar with the art and science of nursing in the Australian context. Twelve out of thirteen nurses offered accounts of some positive experiences that they believed helped them learn and make sense of the clinical environment.

There were three main points that NESB nurses raised in relation to the positive aspects of their clinical experience: the opportunity to work with technology that was new to them, the opportunity to become familiar with the Australian Health Care System, and activities and behaviours on the part of ward staff that they perceived as supporting their learning and professional socialisation.

Hailey, who was of Indian origin, was asked to list three positive things about her clinical learning opportunities:

Good experience because of change with equipment. Lot of change with Australian Health Care System and communication it is good practice for us.

Yesterday and today I got a nice nurse and she was asking do you want to know anything and showed me resuscitation trolley. Hailey, PG2:Ln9&14
A nurse of South American origin summed it up by saying:

*When I ask them they explain to me and that’s one thing that makes me feel happy and motivated.* Alana, PG2:Ln2

Reports from the NESB in relation to their more positive learning experiences depended to a great extent upon the prevailing culture at the clinical venue where they undertook the clinical component of the program:

*Support from the nurse unit manager then the staff and the clinical Teacher it was very good, and I learned Trend Care on the computer.* Jane, PG5:Ln2

These comments highlight the argument put forward by Benner et al. (1996) and MacIntosh (2003) that nurses learn best in a supportive environment where they feel confident to ask questions. Another factor that was reported as contributing to the experience of coping with diversity was collegial relationships that were viewed by some as therapeutic. These referred to collegial relationships with colleagues who were also enrolled in the CBAP and engagement with the research process.

### 7.1.4 Collegial and Therapeutic Relationships

Exploring how the non-English speaking nurses coped with their environment will assist the provision of information to nurse managers through educational initiatives that will help to address the diversity experience for NESB nurses.

Some respondents reported various benefits in relation to how they perceived the cultural diversity of the groups and how diverse views and a cooperative approach to learning helped to sustain them during the period of enrolment:
Chapter 7

Experiencing Diversity

The course are [sic] very broad variety of girls. I got some good
discussion that’s what I thought so far. Deanne, PG1:Ln1

The only thing I can say our classmates are together and share
experience and every day we learn something different we have
to share. Some of them are very quiet, only if you ask them they
talk to you. Alana, PG6:Ln6

These comments seem to reflect cultural values that respect
interconnectedness, sharing and an appreciation of difference as indicated by
this nurse’s comment that some are very quiet and only talk if you ask them.

This gives contextual meaning to the suggestion put forward by Ting-Toomey
(1999) that from a standpoint of creativity, people learn more from those who
are different than from those who are similar. At the individual level this
relates to taking on new ideas, experiencing disequilibrium, and trying to
achieve new synthesis (Ting-Toomey, 1999).

Just a short time following completion of the program a nurse was asked that
if she were to tell a friend about her experience what would she tell them:

I will tell her it is good experience you learn a lot, sometimes
you think it’s hard, some difficulty, but afterwards you get your
registration you will feel very happy and everything will be paid
off. The hardship and difficulty cannot compare with how happy
you feel after the graduation. Leesa, PG9:Ln2

I asked the re-entry nurse “Discriminant Case” how she perceived being in a
group of overseas qualified people and if that affected her, and if she thought
her presence affected them:
I loved it. We had a wonderful time, very caring loving group and we still keep in touch…If we found information we shared it with each other. Susan (“Discriminant Case”), PG5:Ln4-5

Here again there is an expression of appreciation of fellowship and terms such as ‘caring’ and ‘loving’ which could be interpreted as appreciation for interconnectedness and interdependence.

Non-English speaking nurses also reported difficulties coping with the culturally diverse patient populations including English-speaking Australians because of challenges associated with customs and language, formal and informal, as well as with meaning:

*The patients use slang language and we are not prepared for that because in our native language we don’t have formal language and informal language, it’s different and after one week we got better because you talk to patient [sic] all day every day. First week we only have to guess.* Mei Li, PG12: Ln18

They did however, indicate that they found various ways of coping with the communication issues with patients:

*I have to repeat the words to them and do the body language, have to show them where it is, what it is, how it is, and sometimes I don’t know whether they are angry with me or angry with themselves because they cannot understand and cannot express what they want. They are impatient.* Leesa, PG6:Ln1-2
7.2 SUMMARY

A strong element that emerged from data analysis is the need for staff education at the clinical level. Both clinical teachers and non-English speaking nurses provided grounded suggestions as to the content issues that would need to be addressed in that context. A strong feature of that dialogue was the need for information regarding the professional backgrounds and learning objectives of the non-English speaking nurses. In the light of the relevant literature related to diversity management in the multicultural health care team, it is suggested here that strategies to promote cultural awareness among nurses in the clinical environment should also form an integral part of a staff education program.
CHAPTER 8

DISCUSSION
8.1 INTRODUCTION

This study provided an opportunity for nurses of non-English speaking backgrounds and their teachers to provide subjective accounts of their educational experiences whilst enrolled in a CBAP. This chapter will reflect upon the aims of the study and how they were achieved. The main themes will be presented in terms of the issues that the participants experienced as helpful and problematic and how they engaged with and addressed those processes with a view to achieving their own professional and personal goals.

The constant comparative method revealed the NESB nurses’ perceptions of their educational experiences were embedded in a core category that is: *Moving Towards Contextual Competence*. There were three major themes that served to explain the NESB nurses’ move toward contextual competence: *Teaching and Learning, Adaptation, and Experiencing Diversity*. These processes were influenced by intra-personal, interpersonal and contextual factors that paradoxically expedited and impeded the learning and adaptation processes. The following diagrams (Figure 2A and 2B) provide a schematic representation of the meta-cognitive interpretation of these findings. Factors that expedited the process are shown in green and factors that served to impede the process are shown in red. An explanation of Figure 2A and 2B follows and is structured under headings that represent the factors that are believed to impact on the NESB nurses’ perceptions of teaching and learning, perceptions of the adaptation experience, and perceptions of learning and practising in a culturally diverse environment.
Figure 2A. Moving Towards Contextual Competence: Structural Issues. Figure 2A provides a schematic representation of the context of the main themes and their relationship to the intrapersonal, contextual and interpersonal factors that served to shape the experiences of NESB nurses perceptions of their learning experience (Figure 2B).
Figure 2B. Non-English Speaking Nurses’ Accounts of Significant Issues. Figure 2B provides a schematic representation of the intrapersonal, contextual and interpersonal factors that served to shape the experiences of NESB nurses’ perceptions of their learning experience.
8.2 INTRA-PERSONAL FACTORS

There were intra-personal factors that paradoxically complicated and expedited the process of theoretical and clinical learning and professional adaptation for the NESB nurse in the local context. These factors were contextual, environmental, professional, cultural and andragogical. Factors that expedited learning and adaptation will be discussed in the following section.

8.2.1 Factors that Expedite Professional Learning and Adaptation

Intra-personal factors that potentially expedite the process are: professional expertise, reflection, and a remarkable level of personal and professional commitment to the process of moving toward contextual competence.

Professional Expertise

The NESB nurses’ accounts indicated that they were, for the most part, quite confident regarding their clinical skills particularly if they were to have an opportunity to work in the clinical speciality with which they were familiar. However, none of the respondents actually had that opportunity whilst enrolled in the CBAP. They did indicate, however, that they would require mentoring in the clinical environment following registration until they became familiar with the Australian Health Care system and the associated policies and procedures; for example, admission and discharge policies, and various forms of documentation.

Professional and Personal Commitment

There was strong evidence of personal and professional commitment to making the transition to practice in Australia. At the personal level, eleven out of thirteen respondents were enrolled at the relevant universities as full-fee-paying international students and had arrived in Australia approximately one month and in some cases less than a month prior to commencement of the CBAP.
Chapter 8

Discussion

At the professional level the NESB nurses provided detailed accounts of their commitment to learning and professional adaptation through learning at all stages in the program. This was evident from the fact that they identified learning objectives and needs, as well as critiquing the curriculum based, interpersonal and environmental factors that they believed impeded and/or expedited the achievement of those objectives both in the theoretical and clinical contexts. They spoke about various measures that enabled them to cope with the challenge.

*Reflective Practice*

The constant comparative method by its very nature encourages and facilitates reflection on action. The method provides an opportunity for those participating in the investigation to provide a first hand account of how they construct and understand environmental processes, professional interactions, circumstances and contexts as they experience them. Because of the hermeneutical nature of the method, it facilitated the exploration of actions and interactions through reflection on day- to-day experiences, their cause and effects in the current context, comparison with previous experience and understanding, and reconstruction of events leading to alternative understandings that ultimately led to adaptation in varying degrees.

Responses were vigorous in many instances because, by their own admission, the NESB nurses perceived themselves to be in a situation of professional and personal compromise, in terms of experiencing loss of personal and professional power and social position. They also expressed uncertainty regarding their future directions in professional practice.

Although the NESB nurses and their teachers did not refer directly to “reflection in action”, their vivid accounts of their experiences, their questioning of the status quo, their explanations, propositions, frustrations, and detailed reconstruction of
events and interactions, epitomised the process of reflection in action as defined by Schon (1983). Schon (1983:50) suggests that “Usually reflection on knowing-in-action goes together with the stuff at hand”. There is, according to Schon, some puzzling, troubling, or interesting phenomenon with which the individual is trying to deal. The NESB nurses provided evidence of what Schon (1983) describes as the tacit quality of knowing through their ability to recognise events and processes that seemed peculiar to them in the current context, and to compare and contrast new experiences with previous experiences. They recognised that they could no longer rely on the spontaneous, intuitive performance of the actions that would ordinarily show one to be knowledgeable (Schon, 1983) in the course of nursing practice.

Nonetheless, they made judgements regarding quality in the current context and put forward well grounded and logical strategies and suggestions that were relevant in relation to systems of care delivery, job design, learning in the workplace, and skill acquisition and utilisation in the current nurse education environment. It was a combination of their capacity to reflect-in-action and the constant comparative method and techniques associated with it, in particular “multiple perspectives” (Strauss and Corbin, 1994:280), that yielded rich contextual data with which to form a theory grounded in the NESB nurses’ perceptions of their experiences while enrolled in a CBAP.

8.2.2 Intra-personal Factors that Impede Learning

Factors that served to impede learning at the intra-personal level were associated with linguistic, cultural, and professional issues. Professional expectations lead to frustration and disappointment for the majority of respondents, particularly during the early part of the learning encounter. All expressed their own perceptions of the role of the professional nurse. There was marked incongruity
in that regard between expectation and their day-to-day professional encounters in the clinical environment in Australia.

**Cultural and Linguistic Factors**

Language and cultural differences were reported by all NESB nurses as factors that had significant implications for learning and self-confidence in both in the theoretical and clinical learning contexts. However, the impact was more keenly felt in the clinical environment. This may be related to the nature of nurses’ work. According to Hawthorn et al. (2000:194) the nature of nurses’ work brings them into contact with some of the most personal life experiences such as death, birth and direct contact with bodily care. Such situations, according to Hawthorn, raise all the complexities of communication between people, as they bring their values, previous expectation, and communication skills to that encounter. This, according to Davidhzar and Shearer (2005), often creates the most insurmountable problems for students of nursing, particularly when cultural diversity is present in the interaction.

Thompson (1986) explains that communication in health organisations tends to be more complex than in other organisational contexts. This, Thompson suggests, is because of the limited time available to phrase the message clearly, tactfully and supportively, because of the urgency of the task. In addition, most messages in the health care environment tend to be in the form of orders with little time available to explain why the task has to be performed immediately (Thompson, 1986). However, given that NESB nurses have already had considerable experience in clinical settings in their countries of origin and in some cases outside of their countries of origin, it could be expected that they would have a level of awareness of such complexities. The main difficulties relating to language reported by the NESB nurses, however, did not relate to instructions given on the run, but instead to the giving and receiving of nursing reports; interpreting
medical orders and laboratory reports; and communicating with patients, particularly those of NESB. NESB nurses indicated that when patients did not understand them they would try using a different combination of words or a sign. There was always evidence in the responses of a strong element of determination to achieve two-way communication.

Some nurses reported that failure to understand colloquial language used on occasions by patients could pose difficulties with detecting subtle changes in the patients' medical condition. In other words, this possibly relates to what Benner et.al (1996:125) refers to as the “qualitative distinctions that are laden with tone, emotional and attitudinal qualities, as well as action and contextual qualities”. The use of colloquial language by staff also posed problems for the NESB nurses in terms of gaining a complete understanding of the clinical, relational, and social content of messages.

**Staff Expectation**

Giving and receiving nursing reports is the mainstay of communication between nurses in the clinical environment therefore mastery of the task is an important part of the educational and adaptation process for NESB nurses. All NESB nurses reported some difficulties with understanding verbal reports particularly in the early part of the clinical encounter. Unlike the mode of communication spoken of by Thompson (1986), the nursing handover is mostly a face-to-face encounter that occurs away from patient care areas at the commencement and completion of each shift. Communication difficulties in this context were greatly exacerbated for the NESB nurses by intolerant and unprofessional behaviours exhibited by clinical nurses.
**Geographical Challenge**

Geographical challenge associated with the distance of place of residence from the university and clinical venues impacted on the time and energy available for learning. Geographical challenge was compounded by the hours that the respondents were allocated to work, such as an evening shift that finished at 2200 hours and the requirement to commence a morning shift the next day at 0700, with up to two hours, and in some cases more, travel time on public transport to and from the clinical venue. This problem is not, however, confined to NESB nurses although it is a compounding factor in the adaptation challenge. In the NSWNA survey (2002) nurses cited this problem as posing a risk to patient safety due to the personal demands shift work and travel placed on nurses.

In part the burden of travel for the NESB nurses related to the practice of immigration agents organising accommodation that is not in close proximity to the university and clinical placement. These problems accounted for the travelling issues encountered by fifty percent of the sample. Of the other fifty percent, only two people indicated that travel was not a problem. In some cases the problem of distance was exacerbated by change of clinical venue part way through the clinical practice component of the program.

**8.3 Contextual Factors**

*Curriculum Based and Andragogical Issues*

The participants indicated that the theoretical preparation provided in some subjects was inadequate and caused considerable anxiety in relation to practice in the Australian Health Care system. Some concerns related directly to program content and others to andragogical issues such as modes of teaching, continuous exposure to clinical practice without adequate study time, and opportunities to visit the university library. These issues are referred to as andragogical, based on the well founded view (that emerged from the data) that the NESB nurses were
self-directed and according to Kidd (1973) and Knowles (1988) andragogy is based upon the insight that the deepest need of an adult is to be treated as a self-directed person and is student-centred and problem based. Not all would agree that the concepts of Kidd and Knowles are applicable in the case of NESB nurses. This is because it is claimed that nurses from countries such as India and the Philippines are more accustomed to a pedagogical model which is teacher controlled (Rutherford-Dijhuizen, 1995). Nonetheless, in this study there were many examples of NESB nurses taking initiatives to secure their own learning opportunities. However, such initiatives were more likely to relate to the clinical learning environment. The subjects that were reported as problematic and the andragogical issues associated with those subjects will be discussed in the next section.

It is suggested by Fraser (1994) that students have a good vantage point from which to make judgements about classroom education because of their encounters with many different learning environments and that they have enough time in class to form accurate impressions. This is particularly relevant in the case of NESB nurses because of the diverse range of previous learning encounters experienced by most. Some are based in the tertiary system in their countries of origin, for example a nurse from the Philippines, whereas the learning experience of others is in the hospital-based system such as nurses from India, Eastern Europe, South America and China. The main issues that were reported as problematic were the structure and duration of the program and unfamiliar concepts. These matters will receive attention in the next section.

**Structure and Duration of the Program**

The structure of the program gave rise to andragogical concerns in relation to the duration of lectures, with some participants indicating the three hours was excessive in the light of two factors directly related to the learning experience.
Firstly, difficulty concentrating, and secondly, difficulty understanding the content of the material from a conceptual point of view in addition to difficulties with language and accent.

There were concerns regarding lack of adequate preparation time for examinations. This related to the structure of the program with four participants indicating that they were on clinical placement for one month prior to the first examination and had no designated study period. One teacher supported the participants’ views on this and indicated that it distracted the participants from learning in the clinical environment because of the tendency to focus on the examination rather than clinical learning. The same teacher, however, pointed to the theory practice gap in relation to this issue, indicating that NESB nurses can gain great experience in areas such as law, drug administration and informed consent in the clinical environment, but will not actually view that as knowledge acquisition in those areas. This Schon (1987:34) explains in the light of the historical Positivist position, with practice being regarded as being of a lower order than theory. Schon warns that the taint of that hierarchy remains, and that it is at the root of many problems of the integration of the clinical with the theoretical. Similarly, Eraut (1999:12) notes that most practice disciplines tend to overemphasise theory and neglect structures and opportunities for integrated practical experience. This is, according to Eraut, in spite of evidence that front loading theory in nurse education is extremely inefficient. Nonetheless, this does not diminish the need for more appropriate theoretical preparation and an adequate period of preparation prior to examinations.

It should be remembered here that there were slight variations in the program structure between the two universities. The issues have not been specified in line with organisational boundaries. This is in the interest of preserving the identity of organisations and individuals. However, the overarching concerns expressed
by the NESB nurses centred mainly around the same issues, that is: content, duration, structure, andragogy, and learning experiences in the clinical environment.

**Law and Ethics**

In relation to the on-campus theoretical component, the results of this study revealed significant dissatisfaction with the level of knowledge that participants believed they possessed in the area of law and ethics as these phenomena relate to the practice of nursing, as well as with their state of preparedness for assessment in these subjects. NESB nurses indicated that they did not have sufficient theoretical preparation in these subjects and expressed a need for more lectures with a greater emphasis on relating concepts to practice scenarios as the best approach to teaching.

The implication of this for practice is that adequate preparation on the topic is essential to enable the NESB nurses to understand the legal system in Australia as it relates to the practice of nursing. There are range of moral, ethical and legal issues that impact on the daily practice of the nurse, for example, the issues of informed consent, standard of care, duty of care, as well as the ethical principles of autonomy, non-maleficence, beneficence and justice (Johnstone, 1999; Staunton and Chiarella, 2003). This is a complex and challenging area of knowledge for nurses who have previously practised in vastly different legal jurisdictions. It gave rise to concerns in relation to the adequacy of the knowledge base that they believed it was possible to acquire with the level of theoretical preparation available to them.

**Australian Health Care System (AHCS)**

All respondents commented on the AHCS as a subject and on the challenges they experienced in terms of applying the principles in the clinical learning
environment. However, most viewed the subject as an opportunity to make sense of their role in the Australian context, and to that extent explained it as being the most important subject in the curriculum. Criticisms were, however, directed at the fact that the subject was taught in an abstract form rather than with clear links between theory and practice.

**Pharmacology**

Concerns were also expressed in relation to the level of theoretical preparation in the area of pharmacology, with participants indicating that they received one lecture and some self-directed learning time for that subject. They indicated that they did not feel adequately prepared in terms of knowledge base to proceed with the administration of medications in the Australian context.

The interpretation of medication orders posed a significant problem for many NESB nurses, with those who spoke on the issue, that is, eleven out of fourteen, indicating that they experienced difficulties. Those who were interviewed following completion of the program, that is sixty five percent of the sample (excluding the “Discriminant Case”), still expressed concern regarding the administration of medications. Those who raised concerns indicated that poor theoretical preparation combined with difficulties such as interpreting doctors’ orders was a major concern in relation to patient safety and the legal implications of making mistakes. According to Deans (2005), medication administration is probably the highest risk task a nurse can perform and carries with it the potential to lead to devastating consequences for the patient and the nurse in the event of an error occurring. Deans points out that over the past ten years medication errors are recognised as a significant cause of iatrogenic disease in hospital patients.
Poor handwriting and lack of uniformity in terms of the use of the trade or generic names of drugs formed the basis for the NESB nurses’ concerns. The implications here relate to duty of care and, to an extent, informed consent. One NESB nurse expressed serious concern regarding the reluctance on the part of nurses in the clinical environment to check unclear medical orders with the prescribing medical officer. Other concerns related to the practice of Division One nurses being required to administer drugs to patients who were not under their direct care and for whom they did not have an extensive background knowledge in terms of diagnosis and most recent clinical developments.

Deans (2005) suggested that the use of an electronic system of prescribing could substantially reduce the incidence of medication error. This was also a suggestion raised strongly by the participants in this study. The significance of discussing this phenomenon in this section is that it relates directly to legislation in relation to the prescription, storage and administration of pharmaceutical substances (Galbraith et al., 2004; Tiziani, 2006), and as a consequence has a significant degree relevance to the education process for NESB nurses.

**Communication between the University and Clinical Venues**

At the organisational and administrative level NESB nurses’ accounts revealed that there was poor communication between the university department and the clinical venues regarding the NESB nurses’ educational needs and objectives. Many NESB nurses reported that staff seemed to lack understanding regarding their role as undergraduate students and their learning needs and goals. There were also reports of a lack of communication between nurse administrators and clinical nurses regarding the planned clinical rotation. This was evident from the fact that ward staff claimed that they were not aware that a rotation was about to commence. One teacher indicated that staff education would be of value in addressing the lack of knowledge on the part of staff regarding the learning
needs and objectives of the NESB nurses. However, she stated that this could be difficult with staff claiming that they were not expecting students at the time of the rotation.

It is suggested by Rutherford-Dijkhuizen (1995) that because of the unique position educators have to integrate foreign nurses into health care settings, their effectiveness can be enhanced by NESB nurses concepts of health care, cultures and other factors. It is hoped that this research will provide an extended theoretical perspective for both college-based educators and their hospital-based counterparts to become more attuned to the needs and appropriate placement of NESB nurses to facilitate skill development and foster the recognition of specialised skills.

**The Impact of Nursing Culture**

Not surprisingly culture played a major role in the NESB nurses’ perceptions of the work of a Division One nurse in Australia. Not just regional culture, although that was important, but also the culture of nursing and the routines and rituals associated with practice in the Australian context. Culture is defined by Covington (2001:99) as a tool that defines reality for its members and suggests that the health care system is a culture in itself. This culture, according to Gifford et al. (2003) has been found to have an important influence on an individual’s affective reactions to organisational life in hospitals. The cultural norms in the practice of nursing in Australia gave rise to a number of concerns on the part of the NESB nurses. The NESB nurses’ accounts of how they viewed the role of the registered nurse raised questions both in relation to patients’ rights and the optimal utilisation of the professional skills of the Division One nurse.

Previous experience impacts on the nurses’ knowledge base and how they view their role in the delivery of health care (Jackson, 1995). As noted earlier in this
work, routines and rituals are an important part of the nurses’ work. Many such routines are perpetuated through the oral tradition (Street, 1992) and perpetuated from one generation to the next. It is important, however, to remember that since 1986 there has been a progressive and transforming shift in the makeup of the nursing team related to the transfer of nurse education to the tertiary sector (Hawthorn et al., 2000). This process has in effect removed a large volume of cheap and semi skilled labour; the student nurse, from the routine delivery of nursing care. In Australia that work in many instances has now become the domain of the Division One nurse (Herdman, 1998).

Paradoxically then, at a time when many professional commentators claim that the professional and autonomous role of the nurse is growing there is evidence that the process of deskilling for the Division One nurse is occurring with what seems to be equal and opposite force. Some NESB nurses questioned the practice of the Division One nurse spending large blocks of time involved in the provision of basic hygiene and other basic care at the expense of more important professional processes such as patient assessment, therapeutic interventions, monitoring, and evaluation. Assessment, according to Jones and Cheek (2003), is the key to patient management. In a study carried out by these authors examining the scope of nursing in Australia and the skills needed by nurses, it was found that observation, vigilance, and monitoring are among the most frequently utilised tools in the management of patient care. Concern expressed by the NESB nurses regarding the fact that they observed that nurses frequently insisted that patients have a shower prior to conducting any form of physical assessment to assess the patients’ ability to partake in the hygiene ritual would seem to be well justified. This account of the actions of nurses makes the practice of nursing seem more like what Whitehead (cited in Schon, 1983) described as an “avocation”; the antithesis to a profession to the extent that it is “based on
customary activities modified by the trial and error of individual practice” rather than “the application of general principles to specific problem” (Schon, 1983:22).

There are three professional and legal issues involved here requiring the application of legal and ethical principles on the part of the nurse. Firstly, the duty of care (NRNE, 2002) to assess the patient, secondly, the patients right to refuse intervention (Staunton and Chiarella, 2003) and finally, the ethical principle of autonomy (Johnston, 1999).

The question is though, why is this happening? Is it because nurses are incapable of recognising that in these times of growing demand for a more concentrated application of their clinical, technical, legal, teaching, ethical and management responsibilities, that the completion of basic tasks could be delegated to personnel who are appropriately qualified to undertake those tasks? Or, does it relate to the pervasive culture of cost control and the multiple effects this phenomenon exerts on the work of nurses (Buchanan and Considine, 2002; Clark and Clark, 2003; Gifford, Zammuto, and Goodman, 2002) with many areas of nurses work being reduced to tasks because of inadequate staffing levels, leading to a stubborn persistence of what Street (1992) refers to as the task/responsibility dichotomy, despite claims to the contrary by dominant groups.

The move to tertiary education in the 1980s promised, amongst other things, a stronger participation by nurses in health care decision-making. However, according to Daly et al (2006) this does not seem to have filtered down to the clinical level. It is suggested by Daly that many nurses simply do not have the language and the confidence to become involved in discussion on the wider decisions that ultimately affect patient care. Buresh and Gordon (2006 and Gordon 2005) illuminate that view by noting that nurses as a population seem to be unable to clearly articulate what nursing is in professional terms. The
importance of this line of argument here is that it strikes at the heart of the context of the professional education, orientation, as well as knowledge and skill acquisition for the NESB nurse.

The nurse who participated in this project as a “Discriminant Case” mirrored the views of the NESB nurses in a vivid account of what she viewed as management and other contextual factors that in her words “over-burdened the Division One nurse”. In particular she criticised the current system of care delivery (patient allocation) and in general she noted what she described as the apparent inability of nurse unit managers (NUM) to deal with issues arising from the nature of that system. One of the results of this, in her opinion, was the overburdening of the Division One nurse by not allocating work on the basis of qualification and professional ability.

It is noted by Gifford et al. (2002) that job satisfaction among nurses is associated with perceived internal control, that is, the ratios of Division One to Division Two nurses, and Division One nurses to patients. It would be interesting to know how NUM perceived their own job satisfaction, and to what degree they perceived themselves to be in control of the situation. This is one of the limiting factors in this study as has been noted in the relevant section.

The nurse who provided information as a “Discriminant Case”, criticised the patient allocation system on the basis that there were not sufficient registered nurses (Division One) to cover the patient base within the clinical unit at any one time. The result of this for the registered nurse is that in addition to her/his own patient load, she/he is required to attend to medication administration and other technical and clinical matters in the adjacent section of the unit where there is insufficient Division One nurse cover.
She indicated that having a break in her professional practice really enabled her to see the shortcomings in the current system of care delivery and the implications of that for patient safety, nurse workloads, job satisfaction and nurse education. She pointed to the dangers associated with one Division Nurse on occasions being required to attend to medication administration for patients in several sections of the unit without necessarily having had any prior contact with those patients. This the “Discriminant Case” referred to as fragmented care. She expressed the view that for a nurse to be required to administer medications to patients that she/he is not “looking after” is defeating the purpose of the patient allocation system.

**Staff Expectations and Behaviours**

Participants reported unreasonable expectations on the part of clinical nurses. This led to demands on the NESB nurses to function in the immediate term in accordance with the expectations of local nurses. It is possible that such expectations relate to the assumption that a nurse’s role is exactly the same in all regions of the world. An expectation that is criticised by Benner et al. (1996) and Salvage (1995) as unrealistic and lacking in the understanding that context is a crucial moderator in nursing practice. Others also argue that it is unrealistic to expect that practice is similar all over the world, and advise that education and practice experience reflect the needs of the community served (Salvage, 1995; Wickett and McCutcheon, 2002).

Historically however, according to Johnston and Preston (2001) this stems from the expectation of the first employer. Typically, these authors suggest, the new graduate is expected to “hit the ground running” and be adept with all the requirements expected of a nurse experienced in that area. Reports from the NESB nurses indicated that the same expectation applied to them. This expectation is in sharp contrast to the points put forward by other studies.
(Benner, et al. 1996; Wickett and McCutcheon, 2002). The insights put forward by these authors offer a logical and plausible explanation in support of a period of adaptation grounded in situational experience. According to Rutherford-Dijkhuizen (1995) it is important to make a concerted effort to acclimatise foreign nurses.

**Learning Opportunities**

Clinical education plays a key role in the preparation of nurses (Benner et al. 1996; Clare et al., 2003; Johnston and Preston, 2001). There were a number of factors that were cited by the NESB nurses as impacting on their learning opportunities in the clinical environment; among them mentoring and professional modelling. Fourteen participants were interviewed including the “Discriminant Case” and of those who commented two reported positive experiences and ten reported negative experiences in relation to the availability of learning opportunities and the attitudes of clinical nurses toward them and their learning needs.

Non-English speaking nurses were on occasions allocated to work with agency staff, Division Two nurses and inexperienced graduates. This, the NESB nurses believed, was related to a lack of willingness on the part of experienced Division One nurses to work with them. The current shortage of registered nurses however, cannot be ignored in terms of the availability of registered nurses to act as mentors and role models. Two out of three teachers indicated that at least thirty percent of the time students (NESB nurses) were allocated to work with Agency staff or Division Two nurses because there were not sufficient permanent Division One nurses available. Teachers and NESB nurses also commented on the junior status of many of the registered nurses in the clinical environment.
A similar issue emerged in a study conducted by Kilstoff and Baker (2006) involving NESB who were enrolled in a postgraduate nurse education program. The respondents in the Kilstoff and Baker study perceived that most of the staff on the wards were not at the advanced level they believed was necessary to enable them to provide appropriate clinical support to students at the postgraduate level.

These are not isolated incidents as they also featured strongly in the findings of a study conducted in NSW (Buchanan and Considine, 2002). The study explored the reasons why nurses leave nursing. Jones (2002) in commenting on this study indicated that nurses are less able to support each other because of the reduced number of senior registered staff. The problem was cited in that study as one reason why junior nurses left the profession. It is worth noting then that the current shortage is impacting on the quality of clinical learning for pre-registration nurses.

This phenomenon may also be associated with increasing workloads for the average nurse, with relief from such a workload from any source being a welcome bonus. According to Armstrong (2004) hospital admissions have increased by approximately forty percent over the last decade, leading to increased levels of acuity and the associated need for intensive nursing and support. This is at a time when there are fewer nurses available to provide a higher level of care (Clark and Clark, 2003) when there is, in addition, increased productivity expectations (Gifford et al., 2002). Gifford goes on to note that the organisational subunit (in this case the hospital ward) was a key structural factor in the turnover of nurses. These accounts seem to provide a sound basis to reserve the skills and services of the Division One nurse for the provision of specialised nursing care, and the allocation of more basic care activities to staff with lesser qualifications and clinical skills.
On the other hand though, demands and expectations of the NESB nurses could relate to a historical legacy derived from the expectation that the student nurse provides a form of cheap labour in the health care industry. It is recognised that the workplace is not always a learning space (Smith, 2002) and in this case, integral as it is to the preparation of nurses for registration, the findings raised many questions regarding the appropriateness and the educational value of the experience.

In the light of claims that there are increasing levels of acuity (Armstrong, 2004; Buchanan and Considine, 2002; Clark and Clark, 2003; Jones and Cheek, 2003), responsibility, growing recognition of professional autonomy, and growing consumer expectations for accountability (Hawthorn et al., 2000; Jones and Cheek, 2003) it could be expected that the clinical environment would form a rich contextual learning environment (Billett, 2002) for the NESB nurse. However, the findings of this study have revealed that this is not the case in many instances. Indeed the findings revealed many examples of incongruity between the idealised image of nursing conveyed in the professional literature (Conway and McMillan, 2006; Hawthorn, 2000; NBV, 2006; NRNE, 2002), and the actual daily experiences of nurses at ward level as reported by the NESB nurses.

Gordon (2005) suggests that nurses themselves contribute to the issues that keep nursing from achieving the high profile of other professions. Amongst other things she sites image and personal actions for this shortfall. However, in this, one cannot ignore the observation of Gifford et al. (2003) that organisational culture shapes environmental stimuli and experiences that one is exposed to and to which one will react. As such, according to Gifford et al., it will influence individual attitudes concerning outcomes such as commitment, motivation satisfaction, morale, and power.
The findings of this research did not reflect a positive organisational culture that maximised learning experiences. Rather, in many instances, accounts provided by the NESB nurses regarding their own learning experiences within the clinical environment reflected a culture that was fragmented and isolationist.

Peer Group Relationships

Of the NESB nurses who spoke of their peer group relationships with other NESB nurses who were enrolled in the CBAP one nurse indicated that they supported each other and that they enjoyed the cultural and professional diversity they encountered within the group as evidenced by quotes in page 229 in this work.

8.3.1 Environmental Factors

Orientation to the Venue

Lack of basic orientation to the physical layout and the policies in individual clinical units was spoken of as a limiting factor in the transition process. All thirteen NESB nurses indicated that orientation to the physical facility and its policies were more important that learning how to carry out basic nursing procedures. There were six major factors that complicated and limited the orientation process. These were brevity of the physical orientation to various units; the challenge of working in a clinical area that is vastly different in terms of administrative systems, processes and clinical speciality from the nurses’ previous clinical practice; the practice of constantly changing the NESB nurses patient allocation on a daily basis; the need to move from one clinical venue to another part way through the program; and the lack of orientation to policy.

In terms of orientation to the venue, NESB nurses indicated that the process was brief; approximately one hour for each venue. This was problematic because of the challenge associated with memorising the location of materials, equipment, service areas, and areas such as the operating room, medical imaging and other
diagnostic departments. But, more importantly, it created major barriers to learning for nurses who had previously practiced in clinical specialities that were vastly different from their current allocation. An example in this study was a nurse who had practiced as a paediatric nurse for twelve years suddenly faced with the challenge of functioning in an adult medical/surgical unit.

The practice of changing the patient allocation on a daily basis created problems for most in terms of lack of opportunity to gain a complete picture of the patients’ history, current complaint, diagnostic and therapeutic regimes and processes. Yet, teachers indicated that it was necessary to change patient allocation frequently on the basis that the NESB nurses would mainly work with agencies following registration and would therefore not have an opportunity to become familiar with the patients’ medical history and treatment in detail prior to providing nursing care to them. In addition, the NESB nurses experienced constant interruptions from their allocated patients to help in other areas usually with the more heavy, menial and routine tasks.

Finally, policy in relation to admission, discharge, and the associated documentation was problematic for the NESB nurses because regardless of their previous clinical speciality, policy in the Australian context was new for all.

*Policy Related Factors*

*Change of Clinical Venue and Availability of Clinical Placements*

At the policy level, as it relates to clinical education, there seemed to be issues associated with adequate supply of appropriate acute clinical venues available for the clinical education component. This created a need for NESB nurses to move to another venue part way through the clinical placement with consequent disruption to clinical learning and additional geographical challenges.
Partnerships with health care providers have been the subject of concern for academics (Gabb and Keating, 2005) and policy makers alike (Johnston and Preston, 2001; N3ET, 2006; NRNE, 2002) since the transfer of nurse education to the tertiary sector. Organised clinical placement is recognised as the most challenging component of pre-registration nurse education (Clare et al., 2002). It is suggested that many of the challenges associated with this are organisational and financial. Funding has increased for the provision of clinical education (N3ET, 2006). However, it is noted by Daly et al. (2006) that the government needs to follow through on the logistics of applying the Federal Budget 2006-2007 funding for nurse education with provision for clinical placements.

In the mean time it is argued in this thesis that in the light of the findings from this research the current system is inadequate, both in terms of the availability of clinical places and the quality of the clinical learning experience for NESB nurses. Perhaps the most important and relevant facet of revelations and arguments in the latest update from N3ET (2006) is that there is a “need to develop a strategic approach to the allocation of clinical placements that ensures both equity and access for students, quality educational outcomes and innovation through collaborative partnerships.”

It is suggested here that at present in the light of the comments from the N3ET (2006) and the findings from this study, there seems to be a lack of transparency on the part of health providers regarding the allocation of clinical placements to pre-registration students of nursing including NESB nurses enrolled in a CBAP. Daly (2006) noted that the health industry is sometimes slow to respond to requests for additional placements and cites such issues as models of care, resources, and patient acuity, as possible reasons for such delays.
It should be remembered, however, that as long as gridlock exists in relation to the provision of clinical placements, the allocation of additional funding to undergraduate nurse education will achieve little to address the current shortage of nurses. It seems that philosophical and ideological differences that have historically underpinned the tertiary education sector and the health care provider sector (two disciplines that are now by implication inextricably related) provide an ideal platform for political grandstanding.

It seems that a number of significant stakeholders have expressed concern and identified current issues that impact negatively on the quality of clinical education and educational effectiveness (Clare et al., 2002); improving links between theory and practice and emphasising quality over quantity (Ogle et al. 2002); the implications of ineptly managed experience within the clinical setting (Gabb and Keating, 2005); and the recognition that recruitment of extra student nurses could be problematic because of the limited availability of clinical places (Daly et al. 2006). What remains is the need for action. In the view of the current shortage of nurses this is a matter of national if interest. It is suggested here that in the light of the protracted debate and lack of coordinated action on the matter, that coordination of this important facet of nurse education could be more appropriately dealt with at state government level, as a matter of policy and urgency.

This is an area of concern that has been raised in Australia’s Health Workforce Productivity Commission Research Report (2005:79-81) with current clinical training opportunities viewed as having failed to deliver sufficient training for undergraduate students and postgraduate trainees. This has lead to the Australian Council of Deans of Health Sciences suggesting that:
Access to quality clinical teaching placements is likely to emerge as a major limiting factor in any efforts to ramp up professional training programs.

Schools of Nursing, according to this source, currently struggle to ensure an adequate supply of quality clinical placements to offer students the required clinical hours to prepare them for registration. Schools of Nursing, according to the Council of Deans, are at the mercy of the health system where no mandate or inducements exist to offer placements, and that competition between schools for placements perpetuate the problem.

A major impediment to the achievement of a more workable system is apparently located in the interface between the Department of Employment Education and Training (DEST) and State and Territory health authorities in relation to funding for university-based health workforce education and training. There is no formal mechanism in place that links these major stakeholders in a way that ensures university places are better planned and funded (AHW, 2005: 83-84). There is also evidence from this study of ineffective communication between Schools of Nursing and clinical education environments contributing to, but by no means solely responsible for, the poor quality of the clinical education experience for non-English speaking nurses.

8.3.2 Skill Utilisation/Wastage
At the professional practice level all participants in this study expressed some degree of concern regarding their prospects of post-registration employment and the likelihood that they would be required to practice in areas of clinical speciality that were vastly different from their existing clinical expertise. All respondents expressed concern regarding the possibility of gaining employment in their preferred area of speciality.
Ten out of thirteen indicated that they would be relying on the services of an agent to seek employment on their behalf. Three respondents intended to seek employment themselves, but had concerns regarding their professional prospects. All three indicated that the employers they had contacted to date (that is at the time of the last interview) required experience in the Australian context prior to considering them for employment. One person who was a paediatric nurse had commenced employment with a nurses’ agency at the time of her last interview. That nurse was mainly allocated to work in aged-care facilities and adult medical/surgical units, with assignments usually changing on a daily basis. It is ironic that in a time when an acute shortage of professional nurses exists that NESB nurses experience so much difficulty in gaining entry to employment. This particularly so given that there is a perceived shortage of nurses in key areas such as intensive care, acute medical/surgical, and operating room (Jones and Cheek, 2003). Yet, many of these participants were experienced in those areas.

8.4 The Process of Moving Toward Contextual Competence

The NESB nurses were active participants in their own learning and in the research process for this study. They engaged actively with the learning environment by a process of observation, questioning, interaction, and reflection that enabled them to construct contextual meanings. They spoke richly about their perceptions of their learning and adaptation experiences and the challenges of cultural diversity in the CBAP. The greatest motivator seemed to be their commitment to achieving professional registration in Australia.

They spoke of the challenges associated with the preservation of their own professional skills and knowledge and the acquisition of new meanings and ways of applying that knowledge and skill in the current context. The process of the application of existing knowledge and the acquisition of new knowledge and skills was complicated by many intra-personal, curriculum based and
environmental factors including the attitudes and behaviours of nurses in the clinical environment, job design, and systems of care delivery.

All spoke of their commitment to completing the process, that is, completing the program and acquiring contextual competence, and their hopes for professional and economic advancement in Australia. However, some expressed reservations regarding the likelihood of their ambitions being realised in terms of securing professional employment appropriate to their skill mix.

The findings of the study have implications for a number of stakeholders such as nurse educators, regulating authorities, policy makers (health care sector), nurse unit managers, and clinical nurses.

8.5 **Summary**

In summary then, the three main themes that served to explain the NESB nurses’ experience of their learning experiences will be revisited in brief. The teaching and learning has two distinct components that is the learning that took place on campus and learning in the clinical environment.

**Teaching and Learning**

The NESB nurses indicated that for the most part they were pleased with the theoretical component of the program and enjoyed a positive relationship with lecturers at the university level. The main criticisms associated with teaching and learning processes related to subjects with an unfamiliar conceptual base such as pharmacology, law and ethics, and the Australian Health care system. The central focus of concern in relation to these subjects was the degree of conceptual strangeness and the fact that they believed that the material was not presented in a way that enabled them to readily make connections between theory and practice. The lack of a designated study period made it difficult for the NESB
nurses to study for examinations and to complete written assignments particularly during clinical placement. There needs to be more careful consideration of the impact of clinical practice and how this impacts on theoretical understanding and the scope and opportunities to integrate theory and practice.

Clinical Component and Staff Education

The value of clinical education is well documented in the literature and in this thesis. It is important then that the opportunity is provided for NESB nurses to maximise the acquisition of knowledge and to contextualise existing clinical skills. One possible solution to this problem, suggested by the NESB nurses and teachers, could be the provision of staff education at the unit level regarding intra-personal issues such as linguistic and cultural differences, and the variations that exist in the role of the professional nurse in various parts of the world. The NESB nurses, in explaining the difficulties they encountered, suggested an approach to staff education based on information sharing with a view to informing staff about their professional capabilities, past clinical experience and role, as well as their learning objectives in the current situation. Clinical nurses need to be aware that learning and adapting to the current situation are interrelated processes.

Facilitating Adaptive Processes

The importance of role and identity renegotiation cannot be overlooked in the adaptation process. The role and identity renegotiation relates to job design, environmental challenges, and the individual’s perceptions of what constitutes professional practice. This requires a process whereby nurses must acquire and integrate into their lives the expected knowledge, behaviours, skills, attitudes, values, and roles deemed appropriate and acceptable in the Australian context. For this reason it is vital that clinical nurses recognise the need for the NESB
nurse to be provided with a period of professional adjustment in order to facilitate performance at an optimal level. This process is more likely to be hindered than enhanced by constant interruptions and daily reallocation of patient load. The adjustment process is not likely to be linear and the total time required will be influenced by such environmental factors as mentoring, support, learning opportunities, skills and knowledge, ongoing professional development, and appraisal. At the intra-personal level it will be influenced by previous professional education and experience, and previous exposure to culturally diverse communities in the provision of nursing services.

**Experiencing Diversity**

The NESB nurses added to the pool of diversity on campus and in the clinical learning environment. Two of the participants had previously worked outside of their countries of origin and one of those reported that she experienced very little difficulty, but did experience some. The second person who had worked outside of her country of origin, however, reported major challenges with the adaptive process generally, and challenges associated with coping with diversity in the workplace in particular. Culturally diverse patient populations including English-speaking Australians posed problems with understanding for the NESB nurses because of challenges associated with customs, formal and informal language and interpretation of meaning.

The level of acceptance or alienation that the NESB nurses felt on campus and in the clinical learning environment seemed to have the most significant impact on their level of comfort and, consequently, on their ability to engage effectively with the learning and adaptation processes. This varied between clinical learning environments, with reports from one venue in particular revealing a disturbing level of alienation, exclusion, and discrimination leading to feelings of isolation, frustration, humiliation and loneliness.
Figure 3 provides a logical schema intended to facilitate a process that may assist with the acquisition and utilisation of contextual skill amongst NESB nurses with the central aim of addressing skill shortage amongst registered nurses and the planned avoidance of skill wastage. Figure three shows the suggested lines of cooperation that need to take place between the NBV and tertiary institutions involved in the provision of CBAP. This dialogue would involve a review of the existing curriculum so that the content reflects the self-identified learning needs of NESB nurses. This would require expanded coverage of the subjects that were identified as most problematic by the NESB nurses in this study. The review would also need to address the balance between the theoretical and clinical components in terms of the time allocated for each. The sequencing of the theoretical and clinical components needs to be reviewed to allow for adequate preparation time for examinations, access to the university library, the completion of group work during the clinical placement component, and the integration of information. Overall it is likely that the program needs to be extended.

In the next chapter the implications of the findings for key stakeholders will be discussed.
Figure 3. Model for Improvement in Theoretical Learning. This figure is intended to provide a model that may be useful in terms of improving experiences of teaching and learning, adaptation and coping with diversity for individual NESB nurses at the theoretical level, thereby providing a more robust knowledge base for clinical teaching.
CHAPTER 9

IMPLICATIONS FOR STAKEHOLDERS AND A MODEL FOR IMPROVEMENT
9.1 INTRODUCTION

The aim of this research was to gain a detailed understanding of the perceptions of NESB nurses regarding their educational experiences while enrolled in a CBAP. The argument presented throughout this work is that the NESB nurses encountered substantial personal, intrapersonal, interpersonal and structural barriers to learning during the period of enrolment. This chapter is intended to:

- Summarise the main findings and arguments
- Highlight the theoretical perspectives that underpinned and informed and enriched the constant comparative analysis
- Discuss the implications for stakeholders
- State the central elements of the findings; and
- Explain the model for improvement

As indicated in chapter five, the participants fell into three main groups in terms of their previous professional experience. These were:

- Specialist
- Experienced generalist; and
- Inexperienced generalist

Those who fitted the specialist group were nurses who had practised in particular clinical specialities such as operating room and intensive care units for an extended period of time; for example eight to ten years. The group who were classified as experienced generalists were nurses who had practiced in a variety of acute care settings such as medical surgical units. Some nurses who fitted this description had also worked in specialised areas such as accident and emergency. In addition they had diverse experience outside of their countries of origin, for example Indian nurses who had worked in Saudi Arabia. The inexperienced generalists were nurses who had graduated in the previous three years and had experience in one or two clinical areas such as coronary care and surgical units.
However, the level of skill and experience made no difference to the NESB nurses’ experience of prejudice and the lack of support in the clinical environment. The training and clinical experience challenged feelings of competency as much as they expanded feelings of competency. The NESB nurses’ experiences of diversity also challenged their feelings of competence. The implications of this for the profession and the health care system are that even the most experienced specialist and generalist nurses are not having their level of skill appropriately recognised and utilised in a timely way despite the current shortage of generalist and specialist nurses in Victoria.

The second finding is that the level of previous experience did not reduce the concern expressed by NESB nurses regarding the possibility of finding appropriate employment following registration. Moreover, those who were more experienced (the specialist group) expressed the most concern in terms of the limitations of their learning experiences and the potential impact that such limitations could have on their ability to secure appropriate employment following registration. This concern was centred mainly on the fact that they were required to demonstrate competence in clinical areas that differed significantly in terms of the type of skill required in those areas compared to the skills required in their previous professional practice. An example of this is a theatre nurse being assigned to a medical ward.

It is argued here that the current system of skills assessment for NESB nurses holds some merit in terms of providing an opportunity for the NESB nurses to demonstrate generalist skills in the local context. Nevertheless, there is no reason that such competencies could not be judged in the speciality area with which the NESB nurse is familiar, just as are they for postgraduate students of nursing in the current system of postgraduate nurse education. If one is to consider that the NESB nurse is expected to be able to gain competence in the Australian
context within the existing three to four month program, it seems the NBV already acknowledges that those competencies exist to a significant degree. Otherwise, it is likely that the CBAP would be more extensive in content and duration.

It is acknowledged in the stated philosophy of the CBAP that previous knowledge and skill will be acknowledged and new knowledge will be fostered in an environment that encourages self-direction and reflective practice leading to the development of critical and analytical skills, and engagement with the individuals’ creative potential (See footnote)\(^2\). Yet, contextual factors place major limitations on the application of the philosophical underpinnings of the program. It is argued here that the current requirement that all nurses must be assessed in the context of the general ward is inconsistent with this philosophical position. The barriers created by this requirement then place limitations on the identification and utilisation of existing knowledge and skills and the acquisition of contextually relevant knowledge and skill.

**9.1.1 Further Elements of Course Philosophy**

The course philosophy is based upon principles of adult learning and cross-cultural understandings with the primary importance being the delivery of nursing care in a variety of health care settings serving culturally diverse populations. The philosophical position is intended to underpin a learning experience that is designed within a framework of collaboration, inclusiveness and a positive regard for the value of diversity (See footnote). However, despite the seemingly all inclusive philosophical position, the responses from participants, and an ongoing exploration and comparison of the literature in related areas, provided a strong indication that the experiences of NESB who are

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\(^2\) The course philosophy has been taken from the documentation of one participating university and is acknowledged.
enrolled in a CBAP do not vary greatly from those reported by NESB nurses generally (Hawthorn, 2001; Jackson, 1995; Yun-Hee and Chenoweth, 2007). This is particularly so in relation to the clinical learning environment.

In keeping with the constant comparative method a comprehensive theoretical framework was not developed prior to the commencement of the empirical study. However, my views on the emergent themes were influenced to an extent by the views of Benner (1984:38) that if any nurse, even an expert, is required to return to the rules they actually used as a beginner their performance will deteriorate. Therefore context, according to Benner, has a significant impact on the demonstration of competence at any given time. Apart from Benner’s influence then, the core category was allowed to emerge from the data. That was, “Moving Towards Contextual Competence”. Three major interrelated themes emerged from the core category; these were: perceptions of teaching and learning; perceptions of the adaptation experience; and, perceptions of the NESB nurses’ experiences with diversity in the learning environment.

For each major theme the literature was explored with a view to subjecting the emergent themes to a theoretical lens. In this chapter the intention is to highlight the theoretical views on the emergent themes rather than to enter into a detailed discussion on the ways in which the current systems and processes for conducting CBAP for NESB nurses depart from, or are in keeping with, those theoretical view points. This decision relates to the fact that the relevant literature has already been discussed and synthesised in each of the data chapters.

9.1.2 International Students Generally

International students are generally faced with the need to adapt to cultural and social differences (Baker and Hawkins, 2006) and students of nursing in particular are affected by these issues because the compulsory clinical education
component of nurse education brings them face to face with the daily workings of the health care system and the culture of nursing in Australia. These encounters tend to intensify issues associated with learning, adaptation, and the experience of working with culturally and linguistically diverse populations (Kilstoff and Baker, 2006).

In a continuing examination of the relevance of the emergent themes, elements from five major theoretical perspectives were considered, firstly that of Benner (1984; Benner et al. 1996) from the point of view of nurse education. Secondly the theme was viewed from a human resource development point of view (Delahaye, 2005); thirdly, from an adult education perspective (Foley, 2004), fourthly, from the perspective of cultural adaptation (Young, 1998; Ting-Toomey, 1999; Ward et al., 2001), and finally, from a productive diversity perspective (Cope and Kalantzis, 1997).

Benner (1984) argues that any nurse entering a clinical setting where she or he has no experience with the patient population may be limited to the novice level of performance if the goals and tools of patient care are unfamiliar. In addition, according to Benner et al. (1996:75), it is imperative that the nurse works in environments where she/he can feel safe asking questions and where their clinical inexperience is not judged as a personal or professional inadequacy. Benner also points out that environments that are interpersonally threatening to the nurse and punish early mistakes in judgement, or set up barriers to the free flow of questions, are most hazardous to patients. It will be recalled from the data chapters of this work that NESB nurses reported various instances when they did not feel safe to ask questions and feared being regarded as stupid.

In viewing education in the workplace from a human resource development perspective, Delahaye (2005:16) argues that facilitating adult learning is
fundamental to the existence of human resource development. This view supports one of the points of argument in this thesis; that is, that the skills of NESB nurses are a valuable and much need resource in the health care system in the light of the current shortage of nurses at the local level. And, for that reason it is imperative that existing skills are identified as early as possible and the opportunities for the acquisition of contextual knowledge and skills are maximised.

9.1.3 The Productive Diversity Perspective

Cope and Kalantzis (1997:16) view productive diversity as a relationship between perceived traditions and the necessity to negotiate change. They suggest that a way of approaching this would be to replace the singular corporate culture which “produces ghettos”, and instead to cultivate internal variety and permeable boundaries. One of the aims of this chapter is to show the development of a model that has the potential to cultivate such internal variety with a view to ensuring that the skills of NESB nurses are recognised, further developed, and utilised appropriately.

In commenting on the issue of cultural adaptation Ting-Toomey (1999) and Ward et al. (2001) offer a range of theoretical perspectives (some overlapping) on factors that influence the adaptation process. Among the factors mentioned are institutions such as educational facilities and places of work. These institutions according to Ting-Toomey (1999:237) can either help or hinder the adaptation process through the degree of receptivity and helpfulness provided by members of the host community. Similarly, Ward et al. (2001:42) suggest that socio-cultural adaptation is strongly affected by contact variables such as the quantity and quality of relations with host nationals.
It is argued by Young (1988), however, that the successful adaptation of strangers is achieved only when their internal communication systems overlap sufficiently with those of the native people. This, according to Young, enables them to develop ways of seeing, hearing, understanding and responding to their new environment. As many of the NESB nurses involved in this study had just arrived in Australia, it is unlikely for most of them that they would have acquired the cultural overlap described by Young (1998). For this reason it is important that approaches to staff education reflect a commitment to addressing these issues at the clinical education/practice level in the interest of relevance and applicability.

It is argued here that what is important about the process of comparing course philosophy and extant theories with the emergent themes is that, regardless of which theoretical lens was beamed on the emergent themes, it seemed that the conclusion pointed to structures, processes, and interactions that were not conducive to learning, adaptation, and coping with a culturally diverse learning and including the clinical learning environment.

Despite the lofty philosophical ideals that have been stated, the process did not reflect the application of those principles of adult learning and cross-cultural understandings; nor did it reflect nursing care in a variety of health care settings serving culturally diverse populations. The stated philosophical position was not underpinned by a learning experience that was designed within a framework of collaboration, inclusiveness and a positive regard for the value of diversity. It seems that the current system of organisational processes and interpersonal interactions leaves no scope for the stated philosophical ideals, but rather serve to limit the application of existing skill and the acquisition of contextual knowledge skills.
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The constant comparative method provided an opportunity for the NESB nurses and their teachers to provide rich contextual accounts of their perceptions of their educational experiences. In addition it facilitated the application of existing theoretical frameworks and stated philosophical ideals to enhance the interpretation of the emergent themes.

There was, therefore, a theoretical, philosophical, and an empirical basis for the development of model that has the potential to adequately describe, justify, and address the implications of the study for contextually mediated policy. As there are multiple stakeholders involved in the process of providing CBAP, a multi-system approach is required to address the shortcomings that have been identified in this research. In order to delineate this more clearly, the implications of the emergent issues for all stakeholders will be discussed here with a view to highlighting the potential value of the suggestions that will be put forward for organisational change.

9.2 Implications for Stakeholders

9.2.1 The Implications for Policy Makers

The education of NESB nurses is vital if they are to make an effective contribution to the health care system. It is suggested by Buchan et al. (2003) that, among other measures, a policy challenge for employers of NESB nurses in destination countries is to provide a coordinated multi-employer approach to recruitment, multi-agency approaches to coordinated placement, and a period of supervised adaptation and cultural orientation. This is significant because at present it is believed that the main driver for the current high level of international mobility amongst professional nurses is the acute shortage of nurses in Australia and other developed nations (Buchan et al. 2003). This shortage is not just a problem for the nursing profession, but also for the health care system to the extent that it
undermines the effectiveness of the system and therefore requires system based interventions and solutions (Buchan et al. 2003).

Intervention of this nature according to Hancock (2005) requires leadership and stakeholder involvement. The issue of clinical education no doubt holds broader implications in terms of the clinical preparation of undergraduate and postgraduate nurses. This is clear because it is in relation to these populations that the concern was raised in the Australian Health Workforce Research Report (2005). Nonetheless, in these times of acute shortage in the nursing workforce it is argued here that the clinical preparation of non-English speaking nurses bears equal importance.

In addressing the apparent issues associated with the provision of clinical places for pre-registration nursing students generally, it is suggested in the Australian Health Labour Force study (2005) that government intervention opportunities are limited, and that what is lacking is a coordinated mechanism to ensure the smooth functioning of funding mechanisms between the Department of Education Science and Training (DEST) at the federal level, and the Department of Human Services (DHS) at the state level. Surely it is in the interest of these bodies as well as in the national interest that this anomaly is addressed in a constructive and timely manner.

9.2.2 Implications for Course Providers and the Registering Authority (NRA)
Of the nurses who spoke about the duration of the CBAP, nine out of fourteen including the “Discriminant Case” indicated that the program was too short, both in terms of theoretical and clinical preparation. The registering authority has a role in the approval of all courses leading to nurse registration in all states and territories in Australia (ANMC, 2006) in order to ensure that all registered nurses are capable of providing safe care to the health consuming public. This level of
concern amongst NESB nurses therefore has both educational, professional, moral, and legal implications for the educational institutions and Nurse Regulatory Authorities (NRA) who conduct pre-registration nursing courses. This is in view of the fact that their primary responsibility is to ensure that graduates of such programs are safe and competent practitioners (Brackenreg, 2004).

The professional implications relate to the NESB nurses being in a position where they feel competent and confident to seek and take up employment, whereas moral and legal implications relate to the safety of the health consuming public. Universities involved (at the policy level) in the provision of CBAP also have an obligation to ensure that full fee paying students (NESB nurses) are provided with quality educational experiences that reflect the substantial fees paid by individual NESB nurses for that service.

9.2.3 Implications for Nurse Education: Tertiary Level

Non-English speaking nurses indicated that they received support from the lecturers and felt comfortable asking questions and calling on lecturers outside of lecture times to clarify issues. This approach is amongst the strategies put forward by Omeri et al. (2003) and Davidhizar (2005) as being useful in terms of enhancing the learning experiences of NESB students of nursing. The NESB nurses did indicate nonetheless, that their understanding of concepts was at times limited by accents, the pace, and the modes of delivery. This is not an uncommon experience amongst non-English speaking student nurses (Davidhizar, 2005; Kilstoff and Baker, 2006; Shakya, 2000).

The duration of lectures was an issue for some, as lengthy periods sitting in the classroom impacted on their ability to concentrate and exacerbated the
difficulties associated with language and accent. Some NESB nurses indicated that they would appreciate a scenario-based (SBL) approach to learning particularly in relation to the legal subject. Miller et al. (2003:106) suggest that such an approach highlights the unreliable nature of “knowledge” when dealing with a diverse population by encouraging students to explore the variety of possible outcomes to any given scenario rather than relying on one “how to answer”.

The scenario-based learning approach would potentially assist NESB nurses to examine new scenarios, reflect on prior patient care situations, and consider how they would respond to a similar situation in the Australian context. Miller et al. (2003) reported a measure of utility is encouraging undergraduate students of nursing to be involved in the preparation of the scenarios in order to reflect their own professional and personal knowledge. Such an approach, according to Miller et al., provides an opportunity for information gathering and sharing. This strategy is also advocated by others (Davidhizar and Shearer, 2005; Omeri et al., 2003).

Most respondents indicated that they preferred to be active participants in the learning process, but found this difficult with subjects that were unfamiliar such as the Australian Health Care system (AHCS) and law and ethics. The scenario-based mode of teaching is in keeping with the underlying assumptions of andragogy (Jarvis, 1989) that is, amongst other things, that people learn what they need to know and since people are performance-centred in their learning, such learning should be based on relevant problems. Much of the information provided by the NESB nurses regarding their learning reflected this position. They indicated that there is a need for the curriculum to change so that more time is available for theoretical preparation in the areas of pharmacology, the AHCS, and law and ethics. It was also found that the majority indicated that the clinical
placement component of the program was too short and was hindered by obstructive behaviours, lack of support, prejudice, and confusion related to policy and procedural issues as they impinge upon the day-to-day practice of nursing. The current structure of the program did not allow for a period of study prior to examinations and this was reported as being a significant barrier to the preparation for examinations.

This problem was compounded by the lengthy hours in the clinical learning environment with very limited opportunities to visit the university library for the purpose of completing group work and sourcing literature. The clinical environment was also viewed as extremely tiring because of the perceived lack of support and social isolation. This was compounded by the tendency in many instances, for clinical nurses to use the NESB nurses as pairs of hands to complete routine and mundane tasks with little regard for their formal learning needs.

9.2.4 Implications for Clinical Teachers

In contrast to classroom teaching, clinical education takes place in a complex social context where a teacher, in order to secure appropriate learning opportunities, needs to have a working knowledge of the needs of patients, students, and clinicians in the clinical unit (Chan, 2001). The teacher then becomes a significant variable in establishing a learning environment in the clinical area (Rielly and Oerman, 1992) and therefore has the potential to be the key support or the chief barrier to the students’ successful completion of their nursing program (Amaro et al., 2006).

The guided conversations with the clinical teachers who participated in this study demonstrated an awareness of the culturally sensitive nature of the teaching encounter and of the challenges associated with teaching a population who were under a considerable degree of personal, professional, and
environmental stress. According to Reilly et al. (1992) and Andrews et al. (2006) in the clinical learning environment a humanistic climate that supports the learning process is dependent on a caring relationship between teacher and student.

The teachers’ accounts of the tensions that existed between NESB nurses’ learning needs and the opportunities available to them in the clinical environment were discussed sensitively and in a reflective manner.

The majority of NESB nurses believed that the clinical component of the program was too short and that a ratio of one teacher to eight students in that environment was inadequate to meet their learning needs and thereby prepare them adequately for the rigours of practice in clinical areas with which they were not familiar.

9.2.5 Implications for Hospital Managers
Chief executive officers drive health care cultures (Fabre, 2005). According to Jones and Cheek (2003), ongoing flexible approaches to the day-to-day management of nurses and educational preparation in partnership with key stakeholders are a necessity if nursing is to keep pace with the flux of health care systems and attract and retain nurses in nursing. It is suggested here that such strategies are no less important in relation to the educational preparation of NESB nurses.

The clinical provider is one of the most important stakeholders in the education of nurses and for that reason the most important and relevant facet of the revelations and arguments set forth in the latest update from N3ET (2006). These arguments state that there is a “need to develop a strategic approach to the allocation of clinical placements that ensures both equity and access for students,
quality educational outcomes and innovation through collaborative partnerships.” According to Buchan and Calman (2005) it is imperative that employers and the education sector are involved in this process. Despite the fact that financial incentives are minimal it is in the interest of managers to take an active interest and adopt policies that are equitable in relation to the provision of clinical education. After all, hospitals are large taxpayer funded organisations whose first priority is the provision of health care in terms of disease management. They are, however, both historically and presently, also large repositories of contextual clinical knowledge and situated learning opportunities and facilities with the overall capacity to make that facility available to learners. It is therefore in the interest of all concerned to take adequate steps to ensure that such facilities are managed and utilised to meet the growing needs of health care consumers, and the complex clinical education needs of future health care providers. According to current research (Armstrong, 2003; Buchan and Calman, 2005; Stewart et al., 2006) establishing good links between education providers and employers at the local level can improve initial recruitment and retention of qualified nurses in the future.

In addition, Jones and Cheek (2003) suggest that as potential transformational leaders of nurses, managers strongly influence both the work environment and the professional growth of nurses as workers. How managers respond to the various forms of conflict found in the nursing workplace, and whether they are perceived to value and respect nurses and nursing, will be factors that shape nurses’ decision on whether to remain in nursing (Jones and Cheek, 2003). Challenges for managers then, according to Jones and Cheek, include how to be innovative and proactive in an environment of shrinking resources.

In the light of the shrinking pool of Division One nurses that currently exists in Australia, managers would do well to note the advice of Buchan and Calman
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(2005) that workforce planning needs to take into account the profile and dynamics of workforce supply. Others stress the importance of being able to recruit and retain a diverse workforce in order to draw on the full pool of available talent (Ewert et al., 1995; Wells, 2000). This in turn, according to these authors, influences the productivity and effectiveness of organisations. However, where a diverse workforce does exist, the concept of inclusiveness must be emphasised as a major factor in the workplace harmony and productivity, and it is in the interest of managers to support educational measures at the clinical level to foster a culture of inclusiveness.

Fitzsimons and Eyring (1993) suggest that people who are subjected to prejudice and resentment in the workplace; as a number of NESB nurses in this study indicated, tend to have low morale and are less productive than those who are included in informal interpersonal networks. This is particularly important for nurses of NESB backgrounds as they frequently experience negative feedback (Phillips and Hartley, 1990) and many other unsettling experiences in the clinical environment (Jackson, 1995; Kilstoff and Baker, 2006; Omeri, 2004; Omeri and Atkins, 2003; Yun-Hee and Chenoweth, 2007). It is suggested by Omeri (2004) that these issues need to be addressed by Australian nursing credentialing organisations and leaders.

It is suggested here that measures to encourage and facilitate the contextualisation of the skills of NESB nurses would be one worthwhile approach to improving recruitment targets, retention rates, and productivity amongst NESB nurses. These measures would, in turn, aid local nurses as it would help to increase the overall numbers in the workforce. Measures to achieve such an outcome would include, but not be limited to, the education of nurse unit managers and clinical staff regarding the challenges encountered by NESB nurses in the process of contextualising their knowledge and skills, and the value of this
process in terms of skill utilisation. A model intended to provide a basis for this approach is discussed later in this chapter.

It is suggested by Fitzsimmons and Eyring (1993) that a diversity implementation team represents a worthwhile approach to the education of staff and the review of departmental systems, policies, and programs. This approach aims to ensure that creativity is not hindered by guidelines and standards that represent the interests of one monolithic group, but instead are geared toward promoting a common understanding of the organisations goals. This view will form part of the theoretical basis for suggestions regarding how the situation might be improved. It is suggested here that this could be achieved through training for both nursing team leaders and team members in order to improve the ability of these groups to understand different perspectives and different realities as well as lessening social isolation. In addition, it could help team members to engage in self-monitoring behaviour. Suggestions regarding how this training could be implemented will be discussed later in this chapter.

Fitsimmons and Eyring (1993) and Lester (1998) argue that a diverse group can come up with a broader array of ideas and solutions that minimise the problems associated with “group think” that can arise from the lack of self-critical thinking in groups, related to the pre-occupation with maintaining group cohesiveness. Nurses in the current health care environment ought to be encouraged to view diversity as a strength rather than a weakness (Fitzsimmons and Eyring, 1993; Wells, 2000) given the diverse nature of the health consuming population, the increased demand for Division One nurses, and the range of specialist and generalist knowledge and skills to be found amongst NESB nurse population.

It is noted by Hurst (1989) and Phillips and Hartley (1990) that nursing as a profession has accepted diverse patient populations and that the profession now
has the opportunity to accept diverse caregivers. Here again staff education is likely to improve current attitudes in the nurse workforce in that regard.

Without an examination of the assumptions that underlie the organisational culture, changes instituted to ameliorate the organisational environment in relation to cultural diversity are more likely to be cosmetic than substantive (Wells, 2000:197). In a practical setting, according to Wells (2000), cultural proficiency would be demonstrated through a commitment to cultural diversity that is reflected in the institutional mission statement, core values, job descriptions, and employee performance criteria.

It is argued by (Delahaye, 2005) that, in accordance with anti-discrimination and equal opportunity legislation in Australia, the design and implementation of learning opportunities should be free from bias that could discriminate directly or indirectly against an individual or group. However, it is also suggested (Delahaye, 2005; Ewert et al., 1999), that organisations need to be more pro-active than merely responding to legislative requirements if they wish to harness the full potential of a diverse staffing profile. It is suggested that training can improve intercultural effectiveness within an organisation (Ewert et al., 1995; Yun-Hee and Chenoweth, 2007). Ewert et al. also emphasize that training that is planned and ongoing is more effective than short workshops offered on an ad hoc basis as such measures tend not to have long lasting effects. Education then, according to Ewert et al. needs to incorporate at least three building blocks with a view to enhancing organisational effectiveness and it is argued here that these building blocks could form the basis for the staff education program:

1. Cultural knowledge
2. Target unconscious discrimination
3. Promote intercultural skill
The framework that could be useful in terms of implementing these building blocks in the clinical environment will be discussed following an explanation of the relevance of each building block.

**Cultural Knowledge**

It is noted by Wells (2000:197) that cultural development of individuals and institutions from cultural incompetence to cultural efficiency requires commitment. This is because the lack knowledge in relation to the values and beliefs of other cultural groups leads to ineffective utilisation of skills and in some instances to unconscious discrimination. It is suggested that integration is likely to be more successful when active steps are taken to promote interaction within and between groups (Ewert et al., 1995).

There have been many instances in this study where NESB nurses indicated that they were discriminated against, and how such discriminatory behaviours affected their learning and professional performance as well as creating feelings of alienation and isolation. This, according to Ewert et al. (1995), leads to dissatisfaction, reduced productivity and effectiveness, and high turnover. Stoy (2000) notes that multiculturalism brings diversity to practice settings and this can have far reaching implications for the ability of others to learn, and in the long run, for their health and well being.

**Unconscious Discrimination**

Racism and discrimination are frequently unconscious behaviours (Ewert et al., 1995). They are often undiscussed, unconscious, and unexamined (Wells, 2000). Training, according to Ewert et al. (1995), can help people to rethink their assumptions. It is a personal view that a re think of assumptions about work practices and the role of pre-registration nurses (NESB) in itself would go a long way toward providing more accessible learning opportunities and a greater
appreciation of the prior knowledge and skills that NESB nurses bring to the workforce. People have shared needs such as being respected and appreciated, making friends, and contributing to the team effort (Fitzsimmons and Eyring, 1993). Therefore workplace practices that are inclusive rather than discriminatory and alienating will have far more positive outcomes for all stakeholders.

**Promote Intercultural Skills**

According to Ketefian and Porter (2000:129) diversity has multiple meanings, ideological bases, and expected outcomes. In nurse education Ketefian and Porter argue that meanings and outcomes have been codified in the notion of cultural competence. Cultural competence, it is argued, is conceptually framed in patterns of knowing such as empirics, ethics, and personal knowledge. However, White (cited in Ketefian and Porter, 2000) argues that although these conceptualisations adequately describe the nurse-patient relationship they do not account for the context within which interaction of persons occur. It is suggested in the NRNE (2002) that Florence Nightingale (Founder of the British system of nursing) embodied an early principle of multiculturalism; that is, the need to understand the context as well as the patient.

White (2000) describes contextual knowledge as the pattern of socio-political knowing, that is, the socio-political context of the persons, and the socio-political context of nursing as a profession. This way of knowing (contextual knowledge) according to White increases nurses’ understanding of the socio-political and cultural contexts, and the fact that these contexts are interrelated in complex ways. Socio-political knowing then, according to White, makes people aware that various problems are political rather than personal. Rafferty et al. (1996: 685) illuminate this concept quite well, claiming that students of nursing need to be aware of what counts as nursing knowledge at different points in time (and it is suggested here in different social and political contexts) and the politics that
drive the legitimisation of nursing theory and practice. According to these authors such an approach can help students (NESB nurses in this case) to deal with reality shock and make sense of their experience as they confront the ambiguities, uncertainties, and contradictions that characterise their day-to-day professional lives. It is suggested here that lack of such contextual understanding in many instances created confusion for the NESB nurses leading them to question systems of care delivery; nurses’ responses to their attempts to secure learning opportunities; bewilderment with the content of the work that was allocated to them, and the tasks they observed other registered nurses perform; as well as confusion with the local health care and legal systems.

Lack of understanding regarding the significance of socio-political and contextual knowledge on the part of NESB nurses is also likely to be responsible, in part at least, for the insensitive responses on the part of local nurses toward them. This highlights the importance of recognising the difficulties that may be encountered by staff and providing opportunities to debrief and receive support and education on possible ways to deal with such issues (Omeri et al., 2003) at the clinical level.

According to Ewert et al. (1995) training can help improve interpersonal skills in listening, interpersonal communication, conflict resolution, and negotiation. It is suggested by Lester (1998) that educational solutions frequently focus on interpersonal and clinical competence. However, Lester (1998:31) suggests that cultural competence should extend to include the ability of the systems, agency, or individual to respond to the unique needs of populations. In other words, a culturally competent system acknowledges and incorporates the importance of culture at all levels.
Cultural competence according to Lester (1998:32) should be thought of as an educational process that includes the ability to develop working relationships across lines of difference. In practice settings then, education can help nurses in administrative and clinical leadership positions to shape the health care environment and context of care in ways that create the climate and expectation of practice that is culturally competent for all. At the formal level these may include, but not be limited to, the development of appropriate standards of practice, assessment of those standards, and evaluation tools for accountability (Ketefian and Porter, 2000:129).

Finally, research suggests that organisations that are not culturally inclusive waste precious resources and limit their options to mobilise creativity and maximise the potential of a culturally diverse staff (Delahaye, 2005; Ewert et al., 1995; Fitzsimmons and Eyring, 1993). Similarly, it is argued in the NRNE (2002) that management systems in Australia have failed to convert population and workforce diversity into a competitive and economic advantage. According to Fitzsimmons and Eyring (1993:2406) as the demographic and psychographic characteristics of the workforce change, employers must learn to accommodate this growing diversity in its unassimilated form rather than attempting to force it into the mould of the dominant culture. It is further suggested by these authors that by celebrating and cultivating the talents of all employees, organisations benefit financially and position themselves more advantageously for the future.

9.2.6 Implications for Nurse Unit Managers (NUM)

The changing composition of Australian society particularly over the past two decades has resulted in a multicultural workplace. Because of this change, it is suggested by Jackson (1995), it is necessary to examine the issues related to cultural wellbeing within the occupational setting. It is argued by Andrews et al. (2006) that ward managers play a significant role in students’ experiences of
clinical placements because of their ability to affect group cohesion and create a positive learning environment based on mutual trust and respect. This can be achieved through the ward managers’ role in influencing staff attitudes and actions toward nursing students (NESB nurses in this case) during clinical placement and concurrently the quality of teaching that students encounter (Andrews et al., 2006:865).

Non-English speaking nurses may have some difficulty processing information and frequently need to translate from English back to the native language in order to understand clinical deliberations (Kilstoff and Baker, 2006). If this is not understood in the workplace then according to Covington (2001:99) there is a real danger that managers will evaluate those they are responsible for guiding in a negative light. Local nurses also need to be aware that international NESB nurses are not familiar with the culture of the health care setting in Australia in relation to procedures, policies, patient needs, and challenging clinical situations (Kilstoff and Baker, 2006).

A positive climate for a diverse staff must be initiated by the manager (Davidhizar et al., 1999) and in view of the culturally diverse nature of the current workforce, and the acute shortage of clinical nurses, it is vital that approaches to managing the culturally diverse health care workforce are geared toward maximising opportunities for skill and knowledge acquisition. And, ultimately to the provision of nursing services with a view to improving health outcomes and reducing the impact of the current shortage of experienced Division One nurses in the state of Victoria.

According to Cope and Kalantzis (1997) diversity management and multicultural communications are no longer optional extras, but rather core competencies for managers and workers in the context of rapidly disappearing mono-cultural and
monolingual workplaces. It is suggested by Davidhizar et al. (1999) that the manager should interact with minority staff members the same as with all staff members and take time to relate at a personal level. It is also suggested by the same authors that the manager should establish goals for diversity and have measurable outcomes. These goals should be explicit and be tied to consequences.

It is a decade since Cope and Kalantzis (1997) put forward their views. Similar views have been expressed in more recent times (Covington 2001; Davidhizar, 1999; Wells, 2000;) yet it seems these opinions tend to fall largely on deaf ears as behaviour in clinical practice environments, such as those where this study was conducted, remains largely unchanged. It is difficult to say at this point in time why health care providers have not heeded the suggestion put forwarded by these authors. It may relate to a persistence of the belief that vacancies in the nurse workforce can be addressed by resorting to the recruitment of English speaking nurses from traditional source nations. It may also be that organisational values in that regard are merely expressed as a policy statement; that a structured approach has not been developed and implemented through a designated group whose objective it is to increase awareness of the multicultural nature of the workforce, and reinforce the likelihood that this change in culture is set to continue. It is suggested here that such an approach would be worthwhile using a clinical governance approach (Stewart et al., 2006). This view will be elaborated upon later in this chapter.

It is imperative that health care facilities that accept responsibility for the clinical education of undergraduate nurses (including NESB nurses) should make every effort to facilitate that education in a way that achieves the dual goal of delivering safe and competent patient care, as well as facilitating the clinical education process.
It is pointed out by Sonnenschein (1997:41) that managers are responsible for creating an environment in which the contributions of all people are recognised and that in order to do this they need to understand how best to utilise individual differences so that special attributes can be used to achieve organisational objectives. This view was supported by NESB nurses, who indicated that they learn most when staff include them and provide information regarding policies, routines, and contextual knowledge. Non-English speaking nurses also noted that the most important aspect of their professional adaptation related to being competent in the local context and to be trusted and respected by their Australian colleagues. This view has also been put forward by Rutherford-Dijkhuizen (1995).

All of these factors are in line with the findings of Chan (2001) who found that students of nursing learn best when they are and involved in team activities. It also fits with the view of Foley (2004) that adults learn best in the workplace when they become full participants in the community of work.

In this thesis it is argued that the nursing skills of NESB nurses, in many cases specialised nursing skills, are a much needed resource in the current health care environment, and for that reason it is in the interest of all stakeholders to ensure that there is adequate provision for the identification and contextualisation of existing knowledge and skills, the acquisition of new knowledge and skills, and the subsequent utilisation of those skills.
9.3 THE CONCLUSION

The conclusion from this study is that the current system of providing competency-based assessment for non-English speaking nurses is inadequate and wasteful. This is evident when the empirical evidence that constituted the emergent themes is viewed against existing theoretical perspectives, in relation to nurse education, adaptation, and diversity, and the stated philosophies that underpin the provision of CBAP. In the light of this, the system is therefore not fully conducive to the identification of existing specialist and generalist skills and the development of contextual knowledge and skills.

The identification and analysis of intra-personal characteristics, interpersonal relationships and environmental factors relevant to the experiences of the NESB nurses has facilitated the development a model (Figure 4) with a view to guiding stakeholders through the process of improving learning opportunities, as well as skill recognition and utilisation, for NESB nurses enrolled in CBAP.

Education regarding the management of diversity in the workplace needs to incorporate at least three building blocks with a view to enhancing organisational effectiveness (Ewert et al., 1995) and it is argued that these building blocks could form the basic content for the staff education program. These building blocks are:

- Cultural knowledge
- Target unconscious discrimination
- Promote intercultural skill

It is also noted that there are multiple individual stakeholders involved in this phenomenon. However, from an organisational point of view there are two principle stakeholders involved with the tertiary-based education of NESB nurses: the participating universities and participating hospitals.
Figure 4. Model for Improvement: Communication Between Stakeholders in Clinical Learning and Skills Identification. This figure provides a framework to assist with the utilisation of research findings in order to improve learning opportunities and to identify and utilise the skills of individual NESB nurses. This will result in an increased pool of Division One nurses and the availability of specialist and generalist nursing skills for the health industry.
The respective operating environments and organisational cultures of these two organisations affect the daily lives of NESB nurses, local nurses who work in participating hospital units, and patients. At this level then, a bilateral systems approach is suggested to develop a framework for improved liaison between university departments and clinical providers; in other words, improved clinical partnerships. It is suggested here that this would facilitate improved links between theory and practice as well as improved learning opportunities in the clinical environment.

Within that approach a staff education program has been suggested on the basis that learning is important for both personal and professional development and for broader service enhancement (Wilkinson et al., 2004). In order to facilitate the development of a staff education program, a theoretical approach has been developed from a synthesis of elements drawn from three theoretical perspectives: productive diversity (Cope and Kalantzis, 1997), clinical governance, and the learning organisation (Stewart et al. 2006 and Wilkinson et al. 2004).

9.3.1 Staff Education Model

Stewart et al. (2006), in recognising the growing need for collaboration between the tertiary health education and the health industry sectors in Australia, developed a strategy that involved the development of a partnership between a clinician manager and a nurse academic for the purpose of utilising clinical governance literature to enhance management practice. These authors focused on two components of the clinical governance approach: staff appraisal and continuing professional improvement. It is suggested here that a similar approach could be adopted to implement a staff education program aimed at improving learning opportunities and fostering a culture of collaborative diversity in the theoretical and clinical learning environments. The initiative
could be linked to performance appraisal for staff. The current system of competency assessment for the NESB nurses would remain, as would the clinical teacher model of clinical education and evaluation.

**Clinical Governance**

Clinical governance is a system through which organisations are accountable for continuously improving the quality of their services (Stewart et al., 2006). This is important here because it is pointed out by many researchers, such as Benner et al. (1996), that environments that are interpersonally threatening to the nurse and punish early mistakes in judgement are most hazardous to patients. Therefore nurse education is an important factor in the provision of health care. It is acknowledged by Wilkinson et al. (2004) that many organisations are seeking new ways to retain a system of learning within the organisation, “organisational learning”.

Both approaches emphasise cultural change as essential underpinnings to quality improvement (Wilkinson et al., 2004) and this is what makes a combination of these methods appealing for the purpose of the initiative proposed in this thesis, although they differ fundamentally in terms of the logic of action (Wilkinson et al., 2004).

It is noted by Stewart et al. (2006:14) that the clinical governance approach has been successfully applied to develop enhanced systems of performance management for nurses and other health personnel. It has also been utilised to enhance competency-based orientation programs (Stewart et al., 2006:14). However, Stewart et al. (2006) note that criticism of the effectiveness of the clinical governance approach has traditionally focused on a continuing preoccupation with a top-down approach to performance management.
In contrast to the top down approach it is suggested here that solutions to problems that are encountered on a day-to-day basis in the clinical learning and practice environment are best addressed by the stakeholders who experience those problems directly. However, any approach to implement such an initiative would require joint organisational support from both the university and the health care provider.

What is being suggested in this thesis is that a “bottom up approach” similar to that adopted by (Stewart et al., 2006) could be developed with the initial aim of developing a more collaborative process between academic and clinical staff involved in the provision of education for NESB nurses enrolled in the CBAP. In this approach the core alliance (Stewart et al., 2006) would be between the academic staff member responsible for the coordination of the CBAP and the nurse unit manager (NUM) of a nominated unit. Ideally, they would spend time together on a regular basis to discuss specific problems that have been encountered, as well as topics from the available research and associated literature Stewart et al. (2006) in the field of clinical education as it relates to NESB nurses.

The academic staff member and the NUM would form part of a diversity implementation team (Fitzsimmons and Eyring, 1993). The remainder of the team members would be made up of clinical nurses, clinical teachers, and NESB nurses on the same unit. The initial approach to involving clinical nurses, teachers, and NESB nurses would be based on awareness-raising and information sharing. It would ensure that clinical nurses are provided with an opportunity to share their own thoughts and experiences regarding the experience of working with the NESB nurses who are enrolled in the CBAP. This would enable the assembly of a multiple, overlapping, and task-focused work group (Cope and
Kalantzis, 1997). A schematic representation of the staff education model is shown in Figure 5.

Figure 5. Model for the Implementation of a Staff Education Program. This figure provides a schematic representation of the development of a model intended to create an evidence-based approach to improving learning opportunities and outcomes for NESB nurses. It achieves this by providing education for local nurses regarding the challenges the NESB nurses face during their enrolment in a CBAP.

The program would be piloted in one clinical unit and would be aimed at improving professional performance through incorporating cultural knowledge, targeting unconscious discrimination, and promoting intercultural skills (Ewert et al., 1995). This would create an environment where blame is minimised and
education maximised (Wilkinson et al., 2004; Stewart et al., 2006). The literature could be utilised as a basis to initiate and enhance discussion, awareness-raising and an understanding of the challenges faced by NESB nurses whilst enrolled in CBAP. This form of collective learning according to Stewart et al. (2006) can realise potential gains for the individual and the organisation.

Gifford (2002:14) noted that, organisational culture shapes the environmental stimuli and experiences to which one is exposed and to which one will react. As such, it directly and indirectly influences the quality of working life. Therefore, the desired outcome of the approach suggested here would be a shift in organisational culture involving a shift in attitudes and behaviours on the part of clinical nurses toward their non-English speaking colleagues. The ultimate aim of the approach would be to forge a culture of collaborative diversity (Cope and Kalantzis, 1997). This could lead to educational benefits for the NESB nurses in terms of expediting skill identification and utilisation, and improved learning opportunities and outcomes in the clinical environment. Ultimately this approach has the potential to benefit local nurses in terms of an increased pool of specialist and generalist nursing skills. It could also benefit the health industry by increasing the pool of registered nurses.

There are also potential benefits for the academic member in terms of maintaining contemporary knowledge (Stewart et al., 2006) of the day-to-day issues associated with the provision of education for culturally diverse nurses in the clinical environment. In addition, it has the potential to provide an opportunity to monitor the relevance and effectiveness of the philosophical underpinnings of the CBAP.

Although the model proposed here is primarily “bottom up” (Wilkinson et al., 2004) it would have a element of the clinical governance approach because of the
link to senior management via a reporting mechanism and a sharing of relevant literature between the diversity implementation team and nurse managers at the senior management level (Stewart et al., 2006). An additional benefit is that the approach would not require a financial outlay because it would be derived from a collaborative venture between the stakeholders who are most involved in the cultural interaction and the provision of clinical services.

**Potential Limitations of the Model**

The model would require cooperation on the part the tertiary education provider and the health care provider. It could be stymied at any point by prevailing organisational cultures and conflicting perspectives. For that reason it is important that the staff of the individual clinical unit and the program academic program coordinator assume ownership of the initiative. It is suggested by Cope and Kalantzis (1997) that instead of a self-directed group with the tendency to engage in introspective self-policing, a more suitable approach would be an overlapping task-focused work group that focuses on value intangibles, such as dynamic relationships of difference. This would be an alternative to the quality assurance approach, which according to these authors, has the potential to turn into quantity surveillance.

**Implications of Methodology**

The major reason for choosing grounded theory for this study related to two factors: the complexity of the area to be investigated, and the paucity of existing research (Strauss and Corbin, 1990) relating to the educational experiences of NESB nurses while enrolled in CBAP. According to Stern (1980) and Strauss and Corbin (1990) there is a case for grounded theory in situations where little is known about a particular topic, or where a new and exciting outlook is needed in familiar settings. It was intended to obtain detailed and life-like accounts of the
NESB nurses’ experiences and what they found beneficial and problematic in relation to those experiences.

As the study was conducted with NESB nurses who were enrolled in CBAP in the State of Victoria, alternative applicability of the findings would need to be considered in the light the alternative setting or situation. A careful description of the sample has been provided, as well as the selection process and context in terms of the time, place and circumstances. Details regarding data collection and analysis procedures as well as documentation processes throughout the project have also been outlined and explained. Experiential statements that reflected the lived experiences, behaviours context, emotion, feelings and interactions of the participants (Strauss and Corbin, 1990), and their accounts of the contextual factors that shaped and impinged on their experiences have been documented. This, according to Lincoln and Guba (1985), could enable those interested in making a transfer to decide whether a transfer can be contemplated as a possibility in another setting or situation.

However, although the study revealed rich description of the educational experiences of the NESB nurses, as well as the perceptions of their teachers, it does not present alternative view points such as the perceptions of clinical nurses in the relevant units regarding their own perceptions of issues associated with the education of the NESB nurses. These views would be useful to provide a more detailed understanding of the contextual and behavioural issues that the NESB nurses reported as problematic. According to Holloway and Wheeler (2002:153) members of a culture or a community analyse the language, appearance and gestures of others and act in accordance with their interpretations. It is on the basis of these perceptions, that they justify their conduct, and this conduct can only be understood in the context in which people function. For this reason it would be useful to explore the points of view of the
clinical nurses in relation to how they perceive the educational needs of NESB nurses and how they perceive their own role in the process of clinical education.

Overall the method was time consuming and labour intensive. Clearly, there is a need for a follow-up study to explicate the perceptions of clinical nurses at the local level. However, this is beyond the scope of an individual researcher and would require a team effort and a budgetary outlay.

9.4 SUMMARY
The aims of this study were:

1. To identify key issues that impact on the professional education, socialisation and adaptation of nurses from non-English speaking backgrounds.

2. To develop a greater understanding of these issues through in-depth interviews, observation, and personal diary entries maintained by the participants.

3. To suggest educational strategies with the specific aim of improving the quality of professional bridging programs and the associated clinical education component.

4. To contribute to the discourse on productive diversity and the management of diversity in nurse education and practice through the development of theoretical perspectives that will be useful to curriculum planners and nurse education practitioners as well as nurse managers, clinical nurses, and policy makers.

These aims have been met using a grounded theory approach to guide the collection and analysis of data. The key issues that impact on the professional socialisation, education and adaptation of NESB nurses have been identified, through in-depth interviews, direct observation and journal entries.
The essence of this thesis is that, in the light of the empirical evidence, the current system of providing education for NESB nurses who are enrolled in the CBAP is flawed when viewed in terms of the relevant theoretical perspectives on nurse education, education in the work place, adult education, adaptation, productive diversity, and the stated philosophical underpinnings for the provision of CBAP. It has been found that the overall educational experiences created challenges to the NESB nurses’ feelings of competence as much as they expanded competence.

Using this evidence and analysis, a strategy has been developed in order to provide education for staff in the clinical environment with a view to bringing about a change in culture at that level. The proposed intervention is intended to improve the organisational learning context using a clinical governance approach to diversity management. The desired outcome of the implementation of the model would be a sharing of information, and an increased awareness of the learning and professional adaptation needs of NESB nurses who are enrolled in a CBAP. It is proposed that this approach has the potential to lead to an improvement in learning opportunities, skill identification and utilisation for NESB nurses, and improved levels of confidence and cultural comfort for local nurses in the relevant clinical environments.

The study has contributed to the discourse on productive diversity and the management of diversity in nurse education and practice through the development of a model that has the potential to be useful to curriculum planners and nurse education practitioners as well as nurse managers, clinical nurses, and policy makers. The application of this model has practical implications for individual NESB nurses in terms of the anxiety caused by unnecessary delays in the identification of existing knowledge and skills, and the feelings of isolation and exclusion. It has implications for the health care delivery system to the extent that the specialist and generalist skills that these nurses
could contribute to the workforce are not fully utilised and are in some case wasted or seriously limited in terms of how, where and when they can be applied.
POST SCRIPT: Participants Reflection on the Research Process

In acknowledgement that involvement in the research process could have been a stressful experience I asked three of the nurses who were observed in practice what the experience of being involved in the research was like for them. I chose to ask these people in particular because the dialogical nature of the relationship (MacIntosh, 2003) between them and myself was more intense than in the case of those who participated in the interview process alone. The responses to these questions are provided below.

It was OK you always planned your time and my time. **Deanne, PG9:Ln3**

It was good because I am willing to talk to you about my fail. I want to [help] another overseas student to find this course is good and helpful for them and you don’t ask me something I’m not satisfied with. **Lei, PG16:Ln3-4**

I asked this Chinese nurse what it was like for her during the times at the hospital when I was there walking around, looking at things that she was doing, talking to her each day, and sometimes several times each day:

Sometimes helpful you know, sometimes I was upset or whatever, and I like to talk to somebody, after I talk I feel better. **Mei Li, PG20:Ln1**

I asked her if she believed the study was useful:

I think the study is useful, but I don’t think it will change. I have nine years experience in [sic] hospital every rule change takes long, long time. **Mei Li PG20:Ln3**
APPENDICES
APPENDIX 1

AUSTRALIAN NURSING AND MIDWIFERY COUNCIL.

NATIONAL COMPETENCY STANDARDS
FOR THE REGISTERED NURSE.
This material has been removed due to copyright it can be found at:
Competency_standards_RN.pdf
APPENDIX 2

INFORMATION AND CONSENT FORM
FOR PARTICIPANTS (NESB NURSES)
Dear Colleague

Nurses coming from non-English speaking backgrounds make a very significant contribution to the nursing profession in Australia. Your knowledge and skills are important because of the culturally diverse nature of Australian society. It is recognized that you bring to the profession valuable knowledge and experience regardless of what region of the world you have come from, or indeed if you have been absent from nursing practice for some time.

As part of my Ph. D studies I am seeking volunteers to participate in some interviews, be part of a group of nurses to be observed in practice and to maintain a professional journal during the course of the study (see attached explanation). I acknowledge that this will mean a measure of commitment on your part. However, you are uniquely placed to provide first hand relevant information regarding your experiences whilst enrolled in the Competency Based Assessment Program, and consequently to make a significant contribution to understanding the educational and professional adjustment needs of nurses like you now and in the future.

This kind of understanding could help nurse educators and policy makers to provide improved support services for overseas-qualified nurses of non-English speaking background in the future.

The first appendix attached to this letter sets out your rights throughout the study, as well as your right to withdraw at any time and the purpose for which the information will be used. The second appendix is to enable you to provide signed consent should you be willing to participate in the study. Should you need to have any of these points clarified please do not hesitate to contact me.

Thank you for taking the time to read this correspondence and I wish you the very best with your studies.

Yours sincerely

Joan Deegan
Important information

Please read this section carefully as it relates to your rights throughout the research process and please feel free to clarify any queries that you may have with Joan Deegan prior to making a decision to participate or otherwise.

Email jcdeegan@ozemail.com.au

The purpose of the study
The purpose of the study is to satisfy the requirement for my PhD degree at La Trobe University.

The aim of this study will be to obtain an in-depth understanding of the perceptions of overseas-qualified nurses from non-English speaking backgrounds in relation to their educational and socialisation experience whilst enrolled in a Competency Based Assessment Program for overseas-qualified nurses.

It is proposed that increased understanding of the issues that impact on the educational experiences and professional socialization and adaptation of overseas-qualified nurses will contribute to the development of a theory to support strategies that will enable nurse educators as well as clinical nurses and other significant stakeholders such as employers to understand the challenges they experience both in the educational system and subsequently the health workforce in Australia.

It is also expected that such understanding will encourage employers and clinical nurses to facilitate greater scope for professional adaptation to the Australian context through enhanced support systems.

What this means for you as a informant in the study
- Your will be required to participate in an initial interview and most likely some follow up interviews with the researcher during the course of your study.
- It will also entail some observation and interviewing by the researcher (Joan Deegan) at the hospital where you will undertake your clinical experience during the course.
- The interviews will be audio taped for analysis later.
- You will have an opportunity to hear the tape recording and view any notes that I make before each session is concluded in order to provide an opportunity for you to correct, add to, or amend any information that you have provided.

Joan Deegan will not be your assessor at the clinical venue for the purpose of making judgements about your clinical competence, nor, will I be involved in any
way with setting and marking your examinations. This will be the responsibility of your preceptor/clinical Teacher and the relevant university lecturers. I will be observing your actions and interactions as they relate to the kind of information that is relevant to the study.

**Important**

- Your participation or otherwise in the study will not in any way interfere with your grades or the assessment processes during the program, nor will it affect your employment prospects following graduation.

- Your participation will not affect any application you may make for permanent residency in Australia.

- You have the right to withdraw from the study at any time.

- Your personal identity will not be disclosed in any report that may be generated from the data collection.

- All information collected during the course of the study will be treated confidentially and it is anticipated that the analysed data will be included as a report in my thesis, possibly presented at conferences and used in other professional articles and published in professional journals, again as a report, not as raw data.

- Academic staff at the university and clinical staff at the clinical venue will not be made aware of information collected as raw data, nor the identity of the individual who provided such information. **Raw data means information exactly as you have stated it prior to being coded and analysed, and/or published as a report in any of the above named media**

- Your written consent will be required prior to the commencement of data collection and will include a declaration that you have read and understood the information that has been provided regarding your rights.
Ethics approval for the conduct of this research has been obtained from La Trobe University Bundoora 3083.

Should you have any concerns regarding the manner in which the research is being conducted at any time during the study, you may contact my supervisor Dr Keith Simkin on (03) 9479 2652 or the Faculty of Humanities and Social Science Human Ethics Committee on (03) 9479 3505. For your convenience please note that complaints to the above mentioned persons should relate only to the research process and to my conduct during the research process and not to issues associated with your academic progress or assessment.

Consent

I  ___________________________________________ of  ________________________________

________________________________________________________________________________

_________________________Post Code  ___________ having read and understood the information provided above agree to participate in the study named herein for the purpose declared herein and for no other purpose whatsoever. I undertake to inform Joan Deegan if I intend to withdraw from the study and I understand that I do not have to provide a reason.

Signed ……………………………Date ……………………

Investigator’s Consent

I agree to conduct the study and disseminate the findings in accordance with the preceding conditions.

Investigator: Joan C Deegan of 24 Tasman Drive Bundoora Vic.  3083.
Signed …………………………………Date ……………………
APPENDIX 3

INFORMATION AND CONSENT FORM
FOR PARTICIPANTS (CLINICAL TEACHERS)
Dear Colleague

Nurses who come from non-English speaking backgrounds make a very significant contribution to the nursing profession in Australia. Their knowledge and skills are important because of the culturally diverse nature of Australian society. It is recognized that they bring to the profession valuable knowledge and experience regardless of what region of the world they have come from, or indeed if they have been absent from nursing practice for some time.

As part of my Ph.D studies I am seeking a clinical teacher to participate in at least one interview with the possibility of a further interview to help me to gain further insight into my research topic i.e. “The perceptions of overseas-qualified nurses from non English speaking backgrounds of their educational experiences in a “Competency Based Assessment Program”.

I acknowledge that this will mean a measure of commitment on your part. However, it will also make a significant contribution to understanding the educational and professional adjustment needs of these nurses now and in the future. This kind of understanding could help nurse educators and policy makers to provide improved support services for overseas-qualified nurses in the future.

The appendix attached is to enable you to provide signed consent should you be willing to participate in the study. Should you need to have any of these points clarified please do not hesitate to contact me.

The identity of all participants and participating institutions will remain confidential.

Thank you for taking the time to read this correspondence.

Yours sincerely

Joan Deegan
Consent

I ______________________________ of ______________________________

-------------------------------------------------------------------------------------------------------

Ph……………………. Mobile Ph………………. having read and understood the information
provided above and the explanation provided to me by Joan Deegan agree to participate
in the study named herein for the purpose declared herein and for no other purpose
whatsoever. I undertake to inform Joan Deegan if I intend to withdraw from the study and
I understand that I do not have to provide a reason. I understand that my personal
identity and that of the institution at which I am employed will remain confidential at all
times and will not be disclosed in any written report or presentation that may result from
the findings of the said study.

Signed ……………………………Date ……………………

I agree to conduct the study and disseminate the findings in accordance with the
conditions that I have explained.

Investigator: Joan C Deegan of 24 Tasman Drive Bundoora Vic. 3083.

Signed ……………………………Date ……………………
APPENDIX 4

ETHICS APPROVAL NOTIFICATION
22 December 2004

Ms Joan Deegan
24 Tasman Drive
BUNDOORA, VIC. 3083.

Dear Ms Deegan,

Rec: Your modifications to your application for ethics approval:

FHEC No.: #576-04
Research Project Title: A study of the perceptions of overseas-qualified nurses of their educational experiences in Australia
Course (student application): PhD
Supervisor (if applicant is a student): Dr Keith Simkin, School of Educational Studies

Your revised information material has now been considered and is approved to commence immediately. No further information is required.

We wish you every success with your research.

Yours sincerely,

[Signature]

Associate Professor Kerreen Reijer
Chair, Faculty Human Ethics Committee.

cc: FHEC Secretary
Supervisor/s: Dr Keith Simkin, School of Educational Studies
APPENDIX 5

DEMOGRAPHIC QUESTIONNAIRE
Dear Colleague

As stated in my earlier correspondence I am about to conduct a study aimed at investigating the educational experiences of non-English speaking nurses in Competency Based Assessment Programs. Thank you for your voluntary participation in this study. As part of the study I need to collect some basic details regarding your previous education, professional experience and the length of time you have been in Australia. Once again your participation is voluntary and all information provided will be treated confidentially.

1. **Length of time in Australia (Please tick)**

   How long have you lived in Australia?
   - 0-3 months
   - 3-6 months
   - 6-12 months
   - 12 month or more (please state the number of years)

2. **Residency Status (Please tick)**

   - Student Visa
   - Permanent Resident
   - Other

3. **Country of origin**

   - What is your country of origin?

4. **General Education**

   - How many years post-primary education have you had? Please include secondary and tertiary education.

5. **Country of initial nurse registration**

   In what country did you undertake your undergraduate nurse education?

   How many years did you study for your basic qualification e.g. 3-4 years

6. **Was the program based in a hospital/clinic college, university or other institution?**

7. **Is your qualification (Please tick)**

   - Certificate
   - Diploma
   - Degree
Appendices

8. Post Graduate Education
   • Have you undertaken any postgraduate education in nursing?
     • In what area e.g. paediatrics, critical care, or other; please state

9. Post Graduate Experience
   • What area of nursing have you worked in since your graduation e.g. general medical surgical, orthopaedic etc.

10. Work experience in countries other than Australia (other than your country of registration e.g. Saudi Arabia, Hong Kong).
    • In what area of nursing e.g. Medical/Surgical, Operating room, Accident & Emergency

11. When did you last work as a Division 1 nurse or the equivalent thereof?
    • Year

Thank you for taking the time to complete this questionnaire.
REFERENCES


References


References


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