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A MULTI-CULTURAL NURSING WORKFORCE: VIEWS OF NEW ZEALAND AND INTERNATIONALLY QUALIFIED NURSES

ABSTRACT

The New Zealand Nurses Organisation (NZNO) conducted an overarching project this year, surveying members who had joined the organisation within the previous five years, to examine their experiences in the workplace and views on a range of topics of interest to NZNO. This paper reports a subset of the data: the experiences and views of both New Zealand qualified nurse (NZQN) and internationally qualified nurse (IQN) newer members of NZNO, focusing specifically on the increasingly multicultural nature of the health workforce. The number and proportion of IQNs in the New Zealand nursing workforce have increased significantly over the last five years, particularly from areas such as Asia and India. Though qualified and experienced as nurses in their home countries, many fail to gain registration with the Nursing Council of New Zealand (Nursing Council), and most of these work as health care assistants (HCAs). Little is known of their workplace experiences in New Zealand. An anonymous online survey was conducted, covering a range of topics from employment, qualifications, NZNO membership activities and member satisfaction. Differential responses allowed IQN and NZQN respondents to be directed to different sets of questions. IQNs were asked about their experiences, aspirations and plans related to nursing in New Zealand, and NZQNs were asked about their views and experiences of working in an increasingly diverse workforce. The survey link was emailed to eligible NZNO members for whom we had email addresses, in February and March 2012. NZNO membership comprises registered nurses, enrolled nurses, HCAs and nursing students. Cohort analyses of the 1298 responses from NZQNs or IQNs only are reported here; ie nurses (IQNs) working as HCAs are included where they have an international nursing qualification, irrespective of whether or not they are registered with the Nursing Council, while HCAs or nursing students without international nursing qualifications were excluded. Results showed some NZQNs perceived deficits in some IQNs' training, cultural awareness and/or English language skills; widespread observation of racism towards Asian and Indian nurses, in particular from patients; and IQNs feeling discrimination, frustration and disappointment at constrained roles, scopes of practice or career opportunities in New Zealand. Similar findings in other countries necessitated the introduction of policy changes and specific programmes to aid integration of the new workforce; these are advocated in New Zealand.

KEYWORDS

Internationally qualified nurses, New Zealand, nurse migration, health care workers, retention, racism

INTRODUCTION

Multiple sources of data agree that the proportion of internationally qualified nurses (IQNs) in the New Zealand nursing workforce has experienced a steady, significant and ongoing expansion (North, 2007; Nursing Council of New Zealand [Nursing Council], 2011; Walker and Clendon, 2012) to the point where more than half of all new registrations with the Nursing Council in the last five years were nurses who have trained outside New Zealand, and more than a quarter of the nursing workforce are IQNs. Additionally, there have been changes to the proportions coming from particular source countries, the proportion

coming from the traditional source countries of the United Kingdom (UK) and Ireland falling, and that from Asia, India and Africa rising (Callister, Badkar, and Didham, 2011).

Similar influxes of IQNs from outside the European Union were experienced in the UK in the 1990s (Nichols and Campbell, 2010) and nurse migration is a global phenomenon, about which a great deal has been written (Kingma, 2008)(a or b??). While much has concentrated on the ethics of nurse recruitment from the developing world to fill skill shortages in wealthy countries (Pearson, 2000; Ross, Polsky and Sochalski, 2005), on the human rights aspects of individual workers (Kingma, 2008)(a or b??), or the policy impacts of nursing shortages

and patient demographic projections (Buchan and Sochalski, 2004), less has been written about the impact on host country nurses, and even less about the New Zealand-specific experience.

Other literature published on this topic has identified recurring themes, especially transition barriers related to language and culture. Hawthorne (2001, p226), writing about the Australian context, suggested "... the transition period to professionalism was associated with doubt and poverty..." Others (Jeon and Chenoweth, 2007) have reported that nurses experienced loneliness, lack of support, marginalisation and difficulties with language.

Further, Nichols and Campbell (2010), in an integrated review of the literature from 1995 to 2007 – a period of rapid and very diverse international nurse recruitment in the UK – reported that "feelings of being devalued and deskilled, not being personally or professionally valued by the UK nursing establishment, and experiencing significant racial discrimination from both patients and colleagues ... have implications for job satisfaction and intention to leave or stay" (p2814).

Tregunno et al (2009) reported on the nursing differences experienced by IQNs in Canada; specifically IQNs reported differences in the expectations of professional nursing practice and the role of patients and families in decision-making. Additional problems with language fluency, causing stress and cognitive fatigue for English as second language (ESL) nurses, were noted. The Canadian study also highlighted the tensions for policy and management decision-makers between increasing the IQN workforce and the delivery of safe patient care – leading to a call from the Canadian College of Nurses to develop post-licensure workplace transition interventions for successful workplace transition and help for IQNs to realise their full potential.

Disquiet about safe communication between UK and ESL nurses has also been widely reported, along with fears that legitimate concerns about language fluency mask deeper concerns (Dhaliwal and McKay, 2008). Racism, aggression, resentment and lack of trust (in

Sex/age	21-25	26-30	31-35	36-40	41-50	51-60	60+
Female	201	187	92	124	282	181	28
Male	22	29	12	16	27	29	1
Blank	1	5	5	6	13	19	6

the adequacy of IQN training) were also described, while Shields and Price (2002), again writing in the UK, found that 64 percent of IQNs reported racial harassment from patients, and 40 percent harassment from colleagues.

Therefore there was an urgent need to examine whether tensions and perceptions of "too fast and too large" a change was affecting workforce coherence in New Zealand, as had been found in other countries, or affecting onward migration intentions of this significant workforce subset.

METHOD

The New Zealand Nurses Organisation (NZNO) is the leading professional and industrial organisation for nurses in New Zealand, with a total membership of more than 46,000, comprising registered nurses (RNs), enrolled nurses (ENs), health care assistants (HCAs) and nursing students (NSs).

A survey was extensively and iteratively designed, combining elements from pre-tested prior NZNO surveys, a review of the literature, and consultation with NZNO members and professional and industrial staff. The questionnaire covered core employment issues (employment sector, location and hours) along with demographic details. Elements were added to explore experience or views of discrimination in the workforce and wider society.

As the overarching project was designed to ascertain the experiences of nurses who were relatively new to practising in New Zealand, NZNO members who joined after 2007 were identified as the primary cohort to send the survey to. The web-based survey was undertaken in February and March 2012. The project was described in an article in NZNO's journal, *Kai Tiaki Nursing New Zealand*, and invitations to participate were sent by email link, along with a covering letter. A reminder email was sent two weeks after the initial invitation to all who had not responded to the first invitation.

Non-nurse newer NZNO members (primarily HCAs and NSs) were included in the survey, and many more topics were covered; full responses are reported elsewhere (Walker and Clendon, 2012). Separate cohort analyses of responses from NZQNs or IQNs were undertaken for this part of the project. Thus nurses (IQNs) working as HCAs were included where they had an international nursing qualification, irrespective of whether or not they were registered with the Nursing Council, while HCAs or nursing students without international nursing qualifications were excluded from the analysis.

The quantitative data were analysed using descriptive statistics and STATISTICA 8. The free text responses were grouped thematically, using NVivo 9 software.

Ethical approval for the study was received from the New Zealand Multi Region Ethics committee: MEC/12/EXP/001.

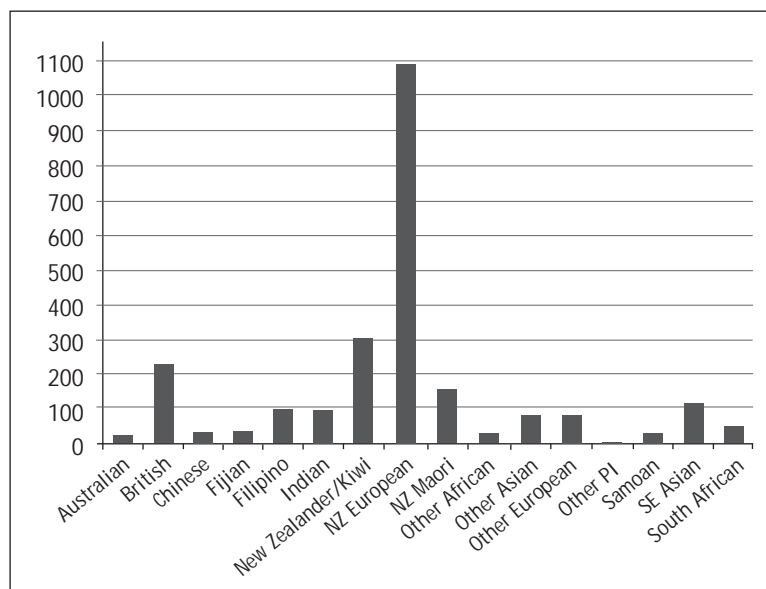


Figure 1. Ethnicity/country of origin of N2N respondents (multiple choices make % not meaningful)

RESULTS

More than 13,600 people had joined NZNO since 2007. Of these, 10,202 had email addresses and were sent invitations to participate; 165 were returned with invalid addresses. A final total of 2162 responses were received, giving a response rate of 21.5 percent. This is considered a good response rate for a detailed web-based questionnaire where one reminder is sent out. A total of 1289 qualified nurse respondents who had joined post-2007 filled in the survey. This group is called the N2N cohort, and is the *main* cohort reported. N2N is further stratified based on initial education as a nurse being done overseas (IQN) or being undertaken in New Zealand (NZQN).

Demographics

Age and gender

The numbers, age and sex of the respondents are shown in Table 1 (previous page).

Ethnicity

Figure 1 (previous page) outlines the ethnicity of respondents (who could make more than one choice of ethnic group). Seventeen respondents also identified as New Zealand Chinese or New Zealand Indian, all except one of whom initially trained as a nurse in New Zealand. Ethnicity of IQN respondents was checked against that of all overseas-trained NZNO members for whom we had email addresses. The proportions were similar, showing the respondents were a good representation of the ethnic mix of NZNO members (Walker and Clendon, 2012).

We also compared the ethnicity of IQN respondents with the most recent New Zealand Census data – the 2006 Census figures for non-New Zealand and Māori nurses and midwives (Callister, Badkar and Didham, 2011). The comparison, in Figure 2 (below), shows the overseas N2N nurses, who have all joined NZNO since the 2006 Census, are coming in proportionally greater numbers from the UK, the Philippines, India and China. The proportional increase in nurses from these four countries since 2006 is consistent with the latest Nursing Council data (Nursing Council, 2011; Nursing Council, 2010).

The Nursing Council figures show that approximately half of all new registrations are from IQNs, with the UK, Philippines, India and China important source countries.

Workplace

Respondents came from all sectors of the health system, but there were differences between the IQN and NZQN groups. Figure 3 (next

page) shows these results.

Twenty-two of the respondents were IQNs who were currently doing further nursing studies. Many Chinese new members, in particular, were currently students – many of them in the process of completely retraining as nurses in NZ.

Registration status

Ninety-one percent of the N2N cohort were registered as nurses (RNs and ENs) with the Nursing Council, and a further 4 percent were awaiting registration. Two percent were not seeking registration – it was unclear why this was so. Forty-eight percent of nurses who originally trained as nurses overseas undertook further assessment to gain registration in New Zealand. A little more than 50 percent took an English language test. The rest were mostly British, American or New Zealand-born nurses who had originally trained overseas and did not need to sit an English language test at the time they registered to practice in New Zealand. Requirements for language testing now apply to all new applicants, though this is again under review. Nearly 20 percent of those who initially trained overseas retrained as nurses in New Zealand. No information was given as to credits for prior learning, which are likely to be variable. Table 2 (next page) shows the country of origin of those who completely retrained on arrival in New Zealand. Of those who completely retrained in New Zealand, 42 percent have so far gained Nursing Council registration to be nurses in New Zealand.

Expectations of nursing

IQN respondents were asked to rank whether nursing and living in New Zealand matched the expectations they had before arriving in the country. Table 3 (next page) shows the results of this question.

Twenty-three percent of IQNs felt they were working in a position with less scope and responsibility than their previous employment in their home country. Of these, the number and percentage by origin answering this question is shown in Table 4 (p8). Thirteen out of 14, or 93 percent, of Other African (Non-South African) nurses thought they were working in a lesser role. In comparison, only two out of 62, or 3.2 percent, of Indian nurses who answered this question thought this. The answers to these questions correlated strongly with Nursing Council registration status.

Free text comments related to this were examined for themes. Many found that due to differences in scopes of practice and training in other countries (especially relating to skills such as venepuncture, cannulation, epidurals, suturing, treating minor injuries, IV medication, vascular Doppler scans, PEG insertion and anaesthetic technician tasks),

not being able to use these skills in New Zealand led to them feeling de-skilled and underutilised. Others, due to geographical location, were unable to get jobs in their previous clinical specialities. Practice nurses, in particular, expressed frustration at not being able to work as previously: eg running chronic disease clinics, and/or titrating and prescribing medication. Several felt that doctors in New Zealand had not passed over responsibility for many of the tasks that nurses were well-trained and capable of doing to the same extent as in other countries. Many (mainly non-UK/USA trained nurses) felt that colleagues distrusted and dismissed their training or experience. One exception was those midwives

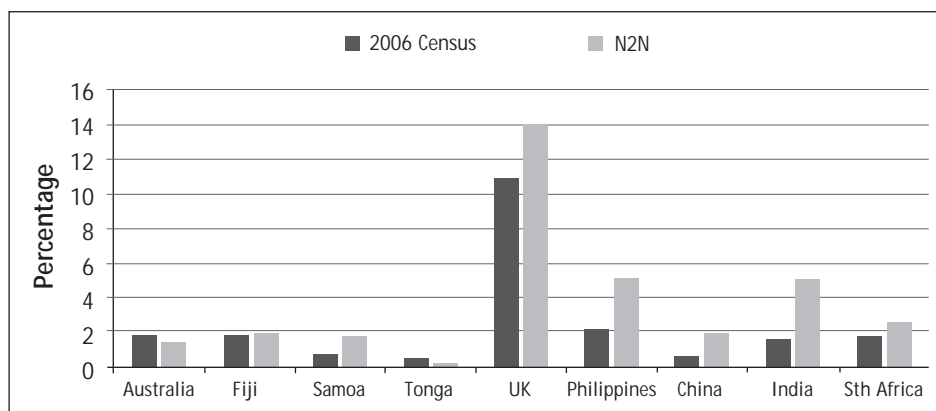


Figure 2. Country of origin of overseas N2N respondents compared to 2006 Census (%)

who felt their skills were more able to be utilised in the New Zealand midwifery setting.

The largest group who felt under-utilised, however, were those IQNs confined to working in aged care as HCAs or care-givers, unable to gain Nursing Council registration, where previously they had been specialised registered hospital nurses.

Representative free text comments related to under-utilisation of prior experience are shown below :

I had [previously] worked in the three separate areas of an A&E department. This included an urgent care centre [consisting mainly of minor injuries], acute beds and the resuscitation area [involving critically ill patients and trauma victims]. Whilst in New Zealand, I have only been allowed to work in the acute beds and I believe my skills have not been fully utilised ... I also feel I have slowly been de-skilled because of this.

I had far more autonomy than I do here and have done lots of further training to enable me to work competently and have maintained these with updates. I also have repeated the courses here to be doing the right way here in New Zealand. Working in primary health care, I have found that GPs are the problem – some work as partners in the area and are supportive and willing to allow nurses to do more; others treat nurses as second class and not willing to share their experience and do not trust nurses to do more.

I feel my skills in IV cannulation, IV drug administration, phlebotomy, oral drug administration, PEG insertion, to list a few, were not fully utilised. I felt at times I was being 'de-skilled' and at times insulted at having to attend study days and re-training. I felt at times that I had more experience and more skills than the people training me.

Some IQNs acknowledged there were important differences between their home country health systems, norms and ways of working, and understood the need to become fully acclimatised to the New Zealand health care system.

Intentions to remain in New Zealand

Of particular importance for workforce planning, given the age profile of the workforce and the size of the IQN pool, are the plans of IQNs to

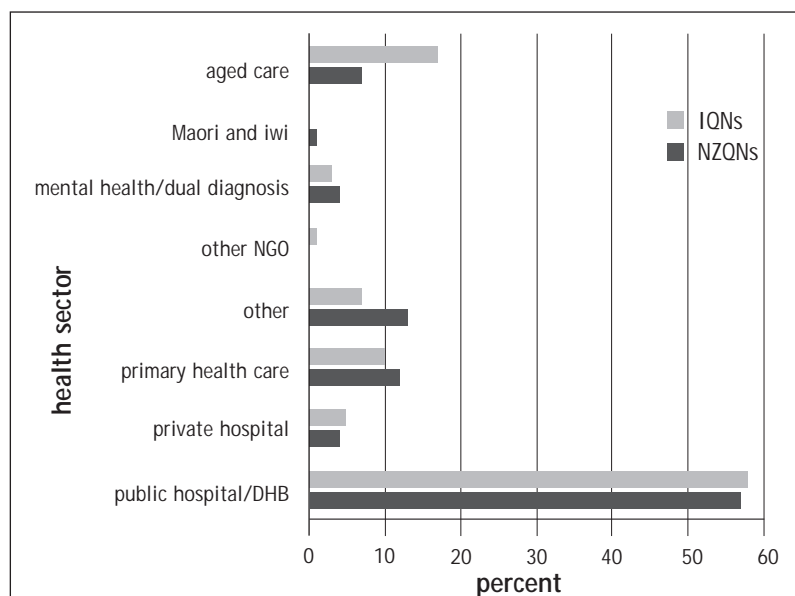


Figure 3. Percentage of IQNs and NZQNs by health sector

Table 2: Country of origin for Nursing Council registered nurses who completely retrained on arrival in New Zealand

Country/origin	Number	Country/origin	Number
Fijian	1	Nigerian	1
Fijian Indian	1	Filipino	76
Indian	17	South African	1
NZ European	3	Tongan/Niuean	1
NZ Indian	1	Chinese	7

Table 3. Expectations of nursing

Question	Yes %	Uncertain %	No %
Does nursing in NZ match your expectations?	63.4	17.9	18.6
Does living in NZ match your expectations?	79.5	12.3	8.2
Do the wages for working as a nurse match your expectations?	46	16.5	37.5
Do the opportunities for career advancement match your expectations?	50.2	21.2	28.6

stay nursing in New Zealand. These intentions differed considerably between countries of origin, and by age, as shown in Figures 4 and 5 (p8).

There is evidence of very different cohorts: older nurses from English-speaking countries who are more likely to stay till retirement; and younger, mainly South-East Asian and Indian nurses, who have not yet decided how long to stay. Of possible concern for New Zealand are the trans-Tasman mutual recognition provisions whereby New Zealand RNs can work in Australia. Anecdotally, New Zealand is the easier country to migrate to, and gain citizenship of within five years. After that, the right to live and work as a nurse in Australia can offer higher salaries and other benefits.

Given previously reported experiences of discrimination (Walker, 2010), a question was specifically asked to ascertain whether this was likely to be a factor in IQNs' decision to stay. The majority (77.85 percent) responded that experience of discrimination at work, or towards migrants in general, did not influence their plans to stay in New Zealand.

Discrimination

Asked about observing or experiencing discrimination, both NZQNs and IQNs reported observing discrimination in a very similar way. Figure 6 (p8) shows observed discrimination by both NZQNs (lower bar) and IQNs (top bar). The numbers represent weighted means (a weighted score was calculated by the percentage answering yes/uncertain/no divided by the numbers responding, allowing comparison) Possible scores range from 0 to 3 – the higher the score, the more discrimination has been observed.

The same issues were largely identified by both groups in free text comments. Fifty-three percent of NZQN and 43 percent of IQN respondents gave specific free text examples of the sorts of discrimination they had observed or ex-

Table 4: Country of origin of those who identified as working in a position with less scope and responsibility

Country	Number	%	Country	Number	%
British	45	35.4	Fijian	3	21.4
Filipino	31	35.6	Indian	2	3.2
Other	15	31	USA	2	40
Sth African	9	34.6	Chinese	1	20
Other African	13	93	Samoan	1	33.3
Other European	4	13.7	Tongan	1	50

perienced. There were also some instances of reverse-discrimination, with some nurses of European descent reporting negative comments from Māori patients. Analysis of free text responses to questions on discrimination identified a range of themes, as outlined in Table 5 (p9). Exemplar quotes are provided to illustrate the themes.

There were a small number (17) of New Zealand-born and educated RNs of Chinese and Indian ethnicity. Virtually all of them reported direct observation or experience of discrimination and racism at work, or in wider society. Illustrative examples of the range of responses from this group include:

Some older patients have strong prejudices against Asian nurses and express these views without reservation. This is irrespective of where we are born or trained ...

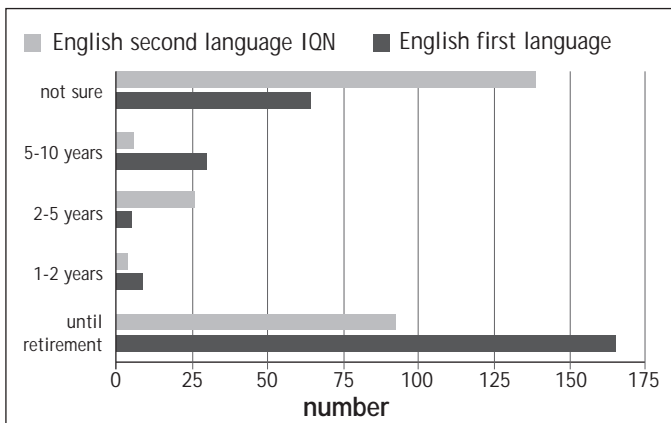


Figure 4: IQN plans to stay, by language of country of origin

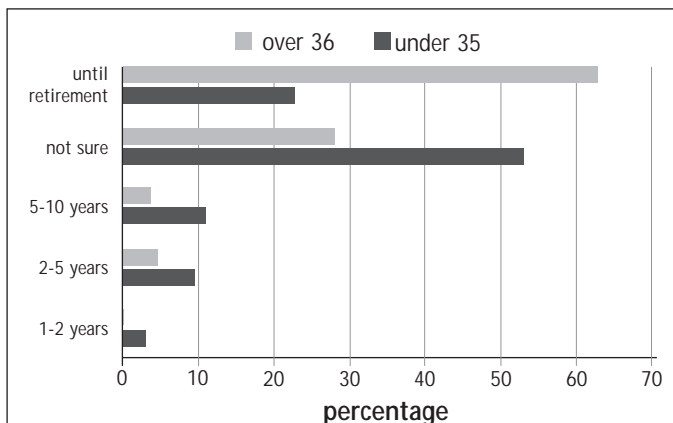


Figure 5: IQN plans to stay, by age

Society does tend to favour the dominant culture and discriminate against minority cultures, regardless of whether those minority cultures are indigenous or immigrant.

One specific issue raised by many NZQN respondents clearly causes friction – that of IQNs communicating with each other in their own languages in the workplace.

Working in a hospital, you see a lot of different ethnic groups; when there is a majority group, ie Indian, what often occurs is they help and support their own ethnic group and ignore the minority and will talk among themselves in their native language, even in front of patients.

One common complaint is that staff from some countries openly communicate with each other in their own language during work time. In this situation, I have just politely asked to be included, and have often received a quick apology.

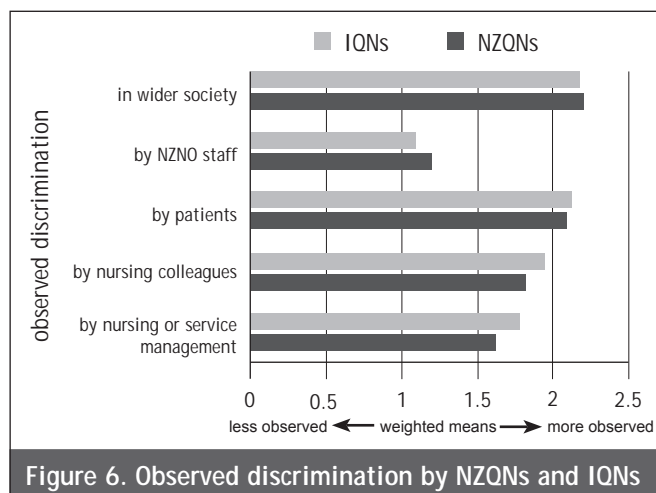


Figure 6: Observed discrimination by NZQNs and IQNs

Finally though, NZQNs expressed considerable support and empathy for IQNs. Many were distressed by the level of discrimination they witnessed in society and the workplace, and offered suggestions on how IQNs could be supported as they made the transition to nursing practice in New Zealand.

Cultural norms are very different worldwide. It takes time to learn the norms of our nursing culture and build up the confidence to take part in it ... I suggest more education sessions and a welcoming environment is needed for international nursing colleagues.

Invite the overseas nurse to describe their training and overseas experiences, so we might understand them and therefore perhaps find out [more] ... they might have experiences that will benefit not only the place of work but also the NZNO.

IQNs also acknowledged that after a period of settling in, the challenges diminished and their ability to reconcile their nursing experiences in their countries of origin with those in their new country improved.

Generally after a while, we all work well together. Small amount of cultural differences may be an issue from time to time. Even language may cause little upsets. I mostly feel New Zealanders are friendly and willing to assist.

There was a huge adaptation period for me, differences in most everything, big and small. This, I initially underestimated.

Although fluent in the English language, idioms, references and cus-

Table 5: Themes relating to discrimination

Theme	Description
Patients refusing care	Very high numbers reported patients saying they did not want to be cared for by a 'foreign' nurse One patient even said: "Why can't the hospital find Europeans to work instead of Asians" and "bloody Asian, go back to your country". Another patient said: "I want to see someone white and important!"
Asian, Indian and Filipino (AIF)	Where specific ethnicities were reported as being subject to discrimination, the largest by far were Asian, Indian and Filipino. Many British nurses commented that integration was easier than for their AIF colleagues. This mostly referred to patient responses. Most of the discrimination I have seen has been toward Asian and Filipino nurses by patients, because the nurses didn't have good English skills, and because of a pervasive sense that "these foreigners are taking over". I've had patients say to me: "Where are you from? Well, thank God you can speak English." Asian nurses appear to be less respected and 'spoken down' to by both management and patients.
Other countries	Anti-South African, German and American sentiments were reported, some based on historical or recent war-time allegiances. Pacific Island nurses were often mentioned as being institutionally undervalued. "I can hear where you come from. Why don't you just go back – we don't need your sort here." I have witnessed managers refusing to interview Pacific applicants because they are perceived to be lazy.
Distrust/disrespect for training	Very many reported sensing a belief that despite Nursing Council verification of training, non-NZ training was inferior. ... the culture in New Zealand nursing is to be suspicious of overseas nurses. After spending all my career in OR, I was asked six weeks into my theatre position if I knew how to scrub up! Although I am over it now, I was very frustrated for quite a long time, as my 24 years of OR experience was not accepted readily.
Language	While NZQNs frequently struggled to understand accents, IQNs reported jargon, accent, idiom and speed of communications causing problems. I have witnessed language barriers causing frustration and impatience from colleagues towards migrant staff. Colleagues have spoken to them like they are of less intelligence, speaking very simply and shortly with them. I have seen them roll their eyes during handovers towards migrant staff, and later talk about them with other colleagues.
Less favourable rosters/workload	Some felt that favourable rosters, workload, access to interviews or promotions were linked to ethnicity, and/or perceived reticence to complain. Treatment and workload division is always unfair, Asians get all the rubbish rosters.
Not valuing prior experience	Separate from differences in scope were feelings that non-NZ experience/service/management was not reflected in grades or progression through grades. Despite my qualifications and extensive nursing experience, I have been told not to apply for senior nursing positions, even though I held those in the UK, 'as you have not done your time in New Zealand'. I trained in India and haven't had New Zealand experience – applications from many of us are being rejected by a lot of employers in New Zealand. Some employers do not consider overseas experience when deciding salary: I am being paid as a fresh graduate.
Other frequent observations	Many either made or reported comments about there being 'too many' IQNs, 'taking Kiwi jobs/promotions', tensions between IQNs from different countries, and many stereotypes about particular cultures. There were clear examples of lack of understanding, respect or tolerance of difference shown by both NZQN and IQN respondents. A colleague said opportunities for New Zealand-trained nurses are fewer, because of all our immigrants. She can't understand how we get employed and New Zealand nurses struggle to get a job. There are too many nurses from overseas coming to NZ to work, no jobs for NZ nurses, too many immigrants coming into New Zealand, taking jobs and cheap housing.

toms were more different than similar. This, on its own, made expressing myself really awkward and understanding me, I believe, even more so. We shared many laughs about this.

LIMITATIONS

There are a number of limitations to this study. Firstly, we surveyed only those who had valid email addresses, immediately ruling out those who do not use email. Secondly, although NZNO membership is widely representative of the New Zealand nursing workforce, use of the convenience sample of new members for whom NZNO had email addresses means some caution should be made in extrapolating the results – for example, the survey does not capture the perspectives of nurses who arrive in New Zealand, are unable to register with the Nursing Council and are not members of NZNO. This group will have specific experiences that will need to be explored in different ways. Additionally, though this paper is reporting findings related to transition to practice for migrant workers, and of observation and experience of discrimination, this was not the main focus of the survey. Also, those who choose to respond to surveys, or who report more extreme views, may not be completely representative of the whole.

DISCUSSION

The findings from this survey echo considerable published research from other countries. In particular, it presents evidence of nurses having widespread experience of patients, and less often colleagues, showing disrespect to IQNs, particularly IQNs from non-English speaking countries, and nurses from Asian and Indian backgrounds. While the levels are significantly lower than those found in the UK by Shields and Price (2002) (where 64 percent of IQNs reported racial harassment from patients, and 40 percent harassment from colleagues, compared to 48 percent and 33 percent in New Zealand respectively), this could nevertheless be expected to similarly negatively affect job satisfaction, self-worth, career progression and staff retention for IQNs in New Zealand.

Patients are a cross-section of the whole population, and racially divisive attitudes are prevalent in society, so it is not surprising that these experiences have

been noted. Harris et al (2012), investigating self-reported racial discrimination among Asian peoples in New Zealand, noted an increase from 28.1 percent in 2002-3 to 35 percent in 2006-7, but that racial discrimination had remained constant at 29.5 percent for Māori, 23 percent for Pacific peoples, and 1-3.5 percent for European respondents over the same period. Experience of racial discrimination was associated in a significant and dose-related manner with negative health measures (Harris et al). Nursing education and values, with an emphasis in New Zealand on cultural safety, may explain why nurses showed more awareness and tolerance to IQNs in this study, compared with their UK counterparts, although this can be further improved.

There was little evidence in this study that experience of discrimination at work, or towards migrants in general, influenced plans to stay in New Zealand. Recent New Zealand research by Harris et al (2012) has re-confirmed, however, that experience of racism is unhealthy, and overseas research conclusively shows that racism in healthcare is not only personally damaging, but also reduces productivity and leads to failure to fully utilise the potential of the workforce (Adams and Kennedy, 2006).

The results of this survey also suggest that the skills and experience of IQNs frequently go unrecognised in the New Zealand workplace. This is also similar to international experience (Ea, 2007). While it is essential to ensure that IQNs meet local standards and expectations, employers may wish to consider more carefully the existing skills and experience of IQNs when appointing them on the New Zealand pay scale. A nurse with several years' experience in a practice area should be able to demonstrate competence quite quickly, compared with a new graduate, and their level of appointment should reflect this. Better recognition of IQNs' skills and experience may have an impact on their intention to remain in New Zealand, reducing costly turn-over, although further work is required to confirm this.

Nurses arriving to practice in New Zealand have to go through a process of adjustment to their host culture known as acculturation, which is a complex, multidimensional process (Brunette, Lariviere, Schinke, Xing and Pickard, 2011; Ea, Quinn Griffin, L'Eplattenier and Fitzpatrick, 2008). Acculturating nurses will both adopt and relinquish the behaviours and attitudes of their own cultures and that of their hosts, as they settle into their new homes and workplaces (Ea, 2007).

Ea outlines three phases to the acculturation process for nurses – cultural contact, cultural negotiation or bargaining, and cultural adjustment. Cultural contact is characterised initially by excitement and expectations of the new country, followed closely by anxiety and disappointment associated with having to learn new roles and work-related tasks as quickly as possible, and realising that expectations may not have been met. Nurses who achieve a sense of balance during this initial phase go on to a phase of cultural negotiation or bargaining, characterised by the need to reconcile their own values and beliefs with those of their host country. Some nurses may report feelings of alienation and discrimination from co-workers and patients during this phase, and that they are "living in two cultures" (DiCiccio-Bloom, 2004). The final phase of cultural adjustment is the period during which migrant nurses embrace their adopted culture and consider themselves part of their work and out-of-work communities.

The acculturation process also acknowledges the place of biculturalism (Buscemi, 2011). Acculturating individuals can maintain two different cultural identities simultaneously (Choi, 2001), with nurses able to negotiate between both cultures without losing connection to their original culture.

The process of acculturation may, in some part, help explain the experiences of the IQNs in this study and the similarity of their experiences with other migrant nurses throughout the world. If both IQNs and NZQNs understood the acculturation process, it would help both groups understand and support each other at work, which could aid the retention of IQNs in the workforce.

Guidance for both IQNs and host country nurses to help migrant nurses make the transition to their new work environments have come out of the UK, USA and International Council of Nurses. This provides a useful framework for New Zealand as we seek to support IQNs making a positive transition into the New Zealand nursing workforce.

The Royal College of Nurses (RCN) in the UK published good practice guidelines for employers for the recruitment and retention of IQNs (RCN, 2005), in response to the publication of a number of studies (Nichols and Campbell, 2010). The RCN emphasised the need to help existing staff understand why overseas nurses were being recruited; to increase trust in the registration and qualification processes for IQNs; and to support the integration and language adjustments required by IQNs for safe practice and mutual trust and respect.

Many similar recommendations were also found in a report by Adams and Kennedy (2006), calling for an international framework to support the positive and safe integration of migrant nurses, and in Ea's (2007) work on facilitating acculturation of foreign-educated nurses in the USA.

Given the 2007 OECD report warning of New Zealand's increasing reliance on IQNs, and the increased international competition to fill the skills gap, supporting the transition of IQNs into the New Zealand workplace is an issue that must be tackled: the benefits to patient safety, improved IQN/NZQN cohesion and productivity associated with a stable nursing workforce, and initiatives aimed at improving professional integration of IQNs in New Zealand merit serious exploration. Development of a good practice guide similar to that produced by the RCN is recommended.

FUTURE RESEARCH

While this study had a credible response rate and a good demographic match with the New Zealand nursing workforce, the issues involved are complex and warrant further in-depth investigation. It is important that we listen carefully to the significant sector of our nursing workforce who trained overseas to help identify priorities for policy and practice, to ensure safe transition and improve retention.

Also, we need to harness the experience and understanding of the New Zealand-trained workforce to better understand their concerns, and to find solutions to improve outcomes for all concerned. Further in-depth investigation of the issues from the perspective of New Zealand-educated nurses is needed.

CONCLUSION

IQNs practising in New Zealand can experience frustration and discrimination in the workplace, and their experiences are common to many migrant nurses around the world.

While the acculturation process may explain some of the experiences identified in this study, it is clear that IQNs require significant support to make a successful transition to New Zealand nursing. The development of a good practice guide is recommended as a means of helping retain IQNs in the New Zealand workforce.

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