An Exploration of the Needs of Migrant Nurses Undergoing Competence Assessment for New Zealand Registration.

- A practitioner thesis to fulfil the requirements for Course 3: Master of Professional Practice: Capable NZ

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Programme: Master of Professional Practice: Course 3


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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), or material which to a substantial extent has been submitted for the award of any other degree or diploma of an institution of higher learning.

28 November 2022

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“Migration is one of the defining issues of the twenty-first century. It is now an essential, inevitable and potentially beneficial component of the economic and social life of every country and region.”

- Brunson McKinley, Director General
  International Organization for Migration, 2007
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<th>Full Form</th>
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<tr>
<td>APC</td>
<td>Annual Practising Certificate</td>
</tr>
<tr>
<td>ARC</td>
<td>Aged Residential Care</td>
</tr>
<tr>
<td>CAP</td>
<td>Competence Assessment Programme</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>IELTS</td>
<td>International English Language Testing System</td>
</tr>
<tr>
<td>IQN</td>
<td>Internationally Qualified Nurse</td>
</tr>
<tr>
<td>NCNZ</td>
<td>Nursing Council of New Zealand</td>
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<td>NZ</td>
<td>New Zealand</td>
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<tr>
<td>NZRN</td>
<td>New Zealand registered nurse</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
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<tr>
<td>OET</td>
<td>Occupational English Test</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Executive Summary

The present enquiry was focused on the professional practice community of nursing. In New Zealand, 30% of the registered nurse workforce is made up internationally qualified nurses (IQNs) – nurses who received their initial professional education outside of New Zealand. As the nurse workforce ages, an increasing number of currently practising nurses will retire. This depletion phenomenon, known as ‘the grey tsunami,’ is predicted to lead to a loss of 50% of the current workforce by 2035 (Koorey, 2016). New Zealand is heavily dependent on the inflow of IQNs. It is becoming increasingly important to understand this group, to be able to attract, retain and develop this essential component of the health care system. While interest has been shown by the research community towards these nurses, this enquiry sought to give them a voice, to let them express what they felt their needs were and therefore to empower them as a previously undervalued and unheard group in nursing in New Zealand. It sought to tell their story.

A case study methodology was chosen as it seeks not to manipulate but to understand a phenomenon or, a case. It aligns with the constructivist paradigm, which aims to find truth through examination of the human experience. The case in the present work-based enquiry is the international nurse who enters the competence assessment process.

Two participant groups represented two perspectives and sources of information to better understand the migrant nurse. Group A was made up of newly arrived international nurses. They were in the first week of their competence assessment programme (CAP) at Otago Polytechnic School of Nursing. A survey methodology for data collection allowed for a greater freedom to respond. The group consisted of 22 IQNs: 10 from the Philippines and 12 from India. An 18-item questionnaire revealed key information around the group: most were motivated to migrate for family opportunities, career progression and financial reasons.

Group B was the second group of participants. These were ten internationally qualified nurses who had been through a CAP programme previously and had been working in New Zealand for several years. There were five nurses from the Philippines, four from India and one from Nepal. They were recruited from notices placed around wards in Dunedin Hospital and aged residential care facilities across Otago. Semi-structured interviews were conducted using a set of eleven questions. This group was chosen as they would be able to reflect back and offer perspectives informed from the years of clinical practice following their original CAP course. Four key themes arose from these nurses’ conversations: Education, Adjustment, Struggles and Communication.

Findings from the two groups of international nurse participants have highlighted the importance of recognising the unique needs that international nurses have as new-entrants and major contributors to the New Zealand health care system. IQNs make up 30% of the...
total nursing workforce and up until only recently have been acknowledged as requiring support.

This enquiry has informed my practice as the leader of a CAP as well my position as international nurse workforce coordinator. It has augmented my role as presenter at the Registered Nurse (RN) Preceptor Course where I teach nurses how to precept international nurses. The following recommendations have come from this enquiry:

- Revise current CAP curriculum content, strengthening areas highlighted by participants, such as: cultural awareness, direction and delegation, de-escalation and conflict management
- Strengthen Māori and Pasifika content
- Incorporate more small group work into course – providing opportunities to develop communication confidence in New Zealand English; and
- Introduce the Prism Model of Migrant Nurse Needs to the Preceptor Course, Te Whatu Ora: Southern
- Pioneer an International Nurse Entry to Practice programme
The Master of Professional Practice (MPP) has been an opportunity for me to explore my professional self within my workplace in the School of Nursing at Otago Polytechnic/Te Pūkenga (subsequent references to the newly amalgamated organisation will be ‘Otago Polytechnic’). Having been employed in tertiary education since 2008, I have had the privilege to work with nurse learners at both the undergraduate and graduate levels. I have been a registered nurse since 1990, working in different countries with nurses from different educational backgrounds. I have spent nearly 20 years working in critical care areas, holding roles from staff nurse to clinical educator to emergency department manager. I felt that it was time to give back to the profession – to share my knowledge and expertise and transition to a new professional role: nurse educator.

My career in nursing has taken me around New Zealand and the globe. While I have worked in critical care areas in London, the most influential work location was in the Middle East. I worked in Riyadh, Saudi Arabia in one of the biggest hospitals in the Kingdom, spending the majority of my time in the Emergency Department, progressing from staff nurse to critical care clinical educator, nurse manager and, finally, as international recruiter for a hospital of over 2,000 nurses. I worked with nurses from many countries and nurse education systems. I believe that this experience was formative and contributed to an international perspective that would continue beyond my return to New Zealand.

My first role in nursing when I returned to New Zealand in 2008 was as a nurse lecturer at the, then, Universal College of Learning (UCOL) in Palmerston North. I became involved in the competence assessment programme, assisting colleagues with teaching and assessing IQNs seeking New Zealand nurse registration. While not having chosen to work in this specialised area of nurse education, I became aware that I was particularly interested in international nurses and their experiences as they moved to new countries to work. I moved to the School of Nursing at Otago Polytechnic in 2015 and within the first two years of employment, I was running the competence assessment Programme CAP and shaping it to become what it is today, the Certificate in Professional Practice for Registered Nurses. I was invited to join the MPP programme and explore my work as a nurse educator.

The MPP journey provided me with an opportunity to reflect on myself as an educator; to better understand myself and my learners. I had already completed a Certificate in Adult Teaching (Advanced) as well as Master of Nursing in Advanced Practice before commencing at Otago Polytechnic. I had become interested in the needs of migrant nurses, entering the CAP and how these needs had been acknowledged and understood by nurse educators and colleagues.
This practitioner thesis is about journeys: brave migrant nurses who journey to New Zealand to be able to work as registered nurses, and my journey as a tertiary educator and assessor of international nurses. The purpose of this work-based project is to learn from these journeys; through reflection and observation, I shall gain a better understanding of the needs of the migrant nurse and how, as a programme leader, I can better meet these needs in the CAP.

The Context and Background section outlines the CAP and places it within the current context of nurse migration. Many people are aware of the presence of international nurses in New Zealand health care settings but have little idea of how their competence to practice is assessed. Major components of the study context include international nurses, global migration, the assessment of practice and the needs of nurses who migrate.

The Literature Review augments the understanding of the context by looking at relevant studies in nurse migration, adjustment and human needs. Nurse migration has been an historical aspect of international nursing and this section explores some of the findings from studies that have examined nurses in global transition.

The Methodology section shows how a needs-based lens can be used to better understand the quality of the migration experience, focusing, in particular, on the initial phase of nurses’ entry into the profession: the competence assessment phase. The study explores the needs of new nurses to New Zealand and seeks to understand if these needs are acknowledged and met through the current CAP at Otago Polytechnic. Using the case study methodology, a group of newly-arrived nurses was surveyed, using a questionnaire. This provided information on the perspectives of ‘naïve’ IQNs. The questions were informed by referencing Maslow’s Classical Hierarchy of Humans Needs. A second participant group consisted of IQNs in the post-registration phase. These participants had been working as registered nurses for at least one year and through interview, provided insight to their CAP experience through reflection. By comparing the anticipated perspectives of the newly arrived nurses with reflections from those who have already assimilated, a more comprehensive understanding of the needs of the migrant nurse is achieved.

Following on from Methodology are the Findings and Discussion sections. Data acquired from the investigations are explored with the identification of key themes. Further analysis and commentary on findings are discussed along with recommendations.
Context and Background

This chapter begins with the context and background of the assessment of professional competence and the phenomenon of nurse migration to New Zealand (NZ). The Competence Assessment Programme is outlined, along with examination of recent statistics concerning registration numbers for nursing. The impact of the global pandemic on nurse registration and the current workforce is discussed, leading on to the motivation to conduct a work-based project around the Competence Assessment Programme at Otago Polytechnic/Te Pūkenga.

The Nursing Council of New Zealand (NCNZ) is the regulator responsible under the Health Practitioner Assurance Act (2013) for maintaining the safety of the public receiving nursing care. Nurses can gain registration in several ways, with all pathways being regulated by the NCNZ. A competence assessment programme for registered nurses is a pathway to registration for IQNs and this programme has been running at Otago Polytechnic since 1984. It is generally a 6–8-week course of study where a nurse’s competence is assessed against 20 criteria from the registered nurse scope of practice (NCNZ, 2022). CAP is a short course that provides an opportunity for the preparation and assessment of the competence of a registered nurse. Successful learners receive a Certificate in Professional Practice for Registered Nurses. The programme is a stand-alone short course and therefore has its own curriculum, made up of two separate courses: one theoretical and one clinical. The New Zealand Qualification Authority designates CAPs as training schemes. This classification is set to change as CAPs will become micro-credentials rather than training schemes. This will not affect the overall structure of the courses.

A pass in each course is required for success in the programme. The nurse is assessed against the four domains of competence that define the scope of practice for a registered nurse in New Zealand (NCNZ, 2007). These are Professional Responsibility; Management of Nursing Care; Interpersonal Relationships; and Interprofessional Health Care and Quality Improvement (NCNZ, 2007). There are two enrolment pathways in the programme: International registered nurse and New Zealand registered nurse. Students enrolled in the programme are regarded as ‘candidates for registration,’ as the emphasis is on professional assessment rather than education. There are approximately 118 IQNs and approximately 12 NZ-trained registered nurses enrolled in the programme each year. A New Zealand registered nurse (NZRN) must meet ongoing competence requirements to maintain an Annual Practising Certificate (APC). If an NZRN has not held an APC for five years or more, they may be required to enrol in a CAP to determine their fitness to practice.

The number of applications from IQNs received by the NCNZ is dramatically increasing. In 2016, 1,573 applications for registration were received – this number increased by 26% in 2017 to see 1991 applications go to the NCNZ (NCNZ, 2017). Of the 3,312 nurses who were added to the register in the 2016-2017 period, 42% were IQNs (NCNZ, 2017). At the beginning
of the global pandemic, between 2020 to 2021, the Nursing Council received 1,872 applications (NCNZ, 2022). Covid-19 has had a major impact on IQNs coming to New Zealand. However, with border restrictions about to be relaxed, interest in migration has ‘exploded’ from the international nurse community. The NCNZ received more than 3000 applications for registration in one month alone in 2022 (Personal communication, 2022).

Nurse migration is impacted by global issues such as political change, financial instability, and a desire to make a better life for succeeding generations. Countries such as Philippines and India are regarded as exporters of nursing workforce. With an over-abundance of nursing schools, enrolment numbers reflect the expectation that graduates will migrate and contribute to the welfare of family through international remittance. The Philippines has one of the highest levels of international remittance contributions to gross domestic product (GDP) with nearly 10% of GDP made up from personal remittance (Dywili et al., 2013; Trines, 2018). With increasing accessibility to New Zealand with direct or near-direct flights now possible, the migration journey has become easier. New Zealand’s financial stability and relatively high standard of living has contributed to migrant nurses’ choices. However, nurse migration has been severely curtailed in the past two years.

The global Covid-19 pandemic has had a major impact on health care systems and nursing workforces (Shaffer et al., 2020). Border closures have stemmed the in-flow of nurses to New Zealand and the consequences from the decreased replenishment of the workforce are being noticed. The aged residential care (ARC) sector has been particularly affected as nearly 50% of ARC nurses are internationally trained (Jenkins & Huntington, 2016). With increased sickness, increased pressure upon health service expansion and decreased workforce replenishment, nursing vacancies have remained unfilled. However, with successful national health strategies to protect the New Zealand population, border restrictions have now been removed, thus reducing travel impediments for migrant nurses.

Migrant nurses are becoming increasingly in demand with Western countries, such as the United Kingdom and United States of America, actively recruiting, using attractive and supported immigration options. The New Zealand government recently released health workforce initiatives to address the increasing global competition for health care workers. International nurses will be able to apply to have their CAP fees paid for by the government along with receiving attractive work to residency visa options. While a consultation and review of the CAP process is currently underway by the NCNZ, the existing system of professional assessment will continue.

The CAP is a significant pathway for nurses gaining registration in New Zealand. There is a growing body of knowledge in the experience of the migrant nurse (Brunton & Cook, 2018; Jenkins & Huntingdon, 2016). Research has revealed that some nurses have been critical of their international colleagues and often cite communication and critical thinking as areas of
concern in clinical practice (Brunton & Cook, 2018). Employers have also expressed concerns around the work-readiness of CAP graduates.

In response to these concerns, organisations such as Presbyterian Support Services Otago and Mercy Hospital, Dunedin have created innovative programmes that recognise the need to support the IQN in the post-registration period. Internationally, it is widely acknowledged that nurses from overseas education institutions do require support – similar to the support that newly-graduated, domestic-educated nurses receive.

As the current leader for the CAP at Otago Polytechnic, I have been working with a relationship manager from Immigration New Zealand to facilitate the preparation of the international nurse for the New Zealand workplace. This initiative has become widely noticed and is being rolled out across the Immigration New Zealand national network of relationship managers. While there are standards for CAPs provided by the NCNZ (NCNZ, 2012), they are brief and non-specific. Programme content is “specific to New Zealand and includes: the Treaty of Waitangi, cultural safety, legislation impacting on the practice of nurses in New Zealand and an update of nursing skills and current practice” (NCNZ, 2012, pp. 2,3). These are wide-ranging topics that have many areas of specialised professional knowledge. For instance, ‘nursing skills’ could include physical assessment, therapeutic communication, urinary catheterization and post-mortem care. Discussions from the annual National Forum for CAP Providers highlighted the variation in content found among the 15 CAPs that currently exist in New Zealand. This does compare with the Bachelor of Nursing curriculum, which varies from School to School, due to there being no national curriculum prescribing the specific content of nursing education in New Zealand. However, a unified curriculum for Bachelor of Nursing Programmes is currently being formulated as polytechnics combine to become one organisation, Te Pūkenga.

From January 2023, all polytechnics and industry training organisations in New Zealand will have been amalgamated to form a new national tertiary education organisation: Te Pūkenga: New Zealand Institute of Skills and Technology. This will mean the unification and standardisation of some degree programmes such as nursing and social work. I am currently working with Te Pūkenga, looking at CAP curriculum across the country. Content and process of CAPs is regulated by the NCNZ. However, variation amongst CAPs continues leading to variation in learner experiences. I have been concerned that the current CAP may not be meeting the needs of the unique group of professionals whose course will directly lead to registration in New Zealand as a Registered Nurse.

While the core curriculum guidelines for the CAP at Otago Polytechnic have not changed, the content of modules within the two-week theoretical component has. The programme has been managed by a succession of academic coordinators over its history – seemingly in an
ad-hoc manner based on candidates’ experience in the clinical placement and feedback from placement providers.

This has raised questions for me: what is the purpose of a CAP? Are we meeting the needs of the key stakeholders: that is, the enrolled candidates? Is the purpose to generate performance-based information to assess whether a nurse is “fit” to practice in New Zealand? Could there also be an implicit purpose, to begin the transition process for the migrant nurse to adjust to working in a New Zealand context?

The NCNZ is currently reviewing the assessment of competence process for IQNs. This may lead to considerable change in the way migrant nurses are assessed. Nevertheless, findings from this research will be important, as they will contribute to submissions made to the NCNZ on proposed changes.
Literature Review

Several key areas of the literature will be examined in this section to provide context to the needs of the international nurse. As this enquiry is focused on international nurses in New Zealand, this chapter will begin with looking at the New Zealand nurse workforce before moving on to examine the phenomenon of nurse migration. Next, the review will look at the experiences of migrant nurses, focusing on significant areas such as isolation, communication, differences in nursing practice, marginalisation and cultural differences. This chapter will conclude with a review of the literature around the classical Maslow theory of human motivation and needs.

The New Zealand Nurse Workforce

There are two main sources of registered nurses in New Zealand: those who completed a New Zealand degree in nursing and those who have qualified elsewhere. IQNs are defined as those who have received their nursing education and initial qualification outside of New Zealand; they make up around 31% of the total of registered nurses in New Zealand (NCNZ, 2022). They are a substantial proportion of the registered nurse workforce and form an essential component of healthcare in New Zealand. The following table shows the distribution of newly registered IQNs by country:

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<tr>
<td>Australia</td>
<td>710</td>
<td>727</td>
<td>748</td>
<td>740</td>
</tr>
<tr>
<td>Canada</td>
<td>19</td>
<td>31</td>
<td>32</td>
<td>15</td>
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<tr>
<td>India</td>
<td>322</td>
<td>675</td>
<td>922</td>
<td>794</td>
</tr>
<tr>
<td>Ireland</td>
<td>13</td>
<td>26</td>
<td>29</td>
<td>11</td>
</tr>
<tr>
<td>Philippines</td>
<td>765</td>
<td>899</td>
<td>1,158</td>
<td>639</td>
</tr>
<tr>
<td>Singapore</td>
<td>5</td>
<td>17</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td>South Africa</td>
<td>14</td>
<td>26</td>
<td>37</td>
<td>24</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>105</td>
<td>294</td>
<td>248</td>
<td>112</td>
</tr>
<tr>
<td>United States</td>
<td>46</td>
<td>35</td>
<td>53</td>
<td>54</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>64</td>
<td>106</td>
<td>75</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,477</strong></td>
<td><strong>3,394</strong></td>
<td><strong>3,368</strong></td>
<td><strong>1,650</strong></td>
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The number of IQNs seeking to migrate to New Zealand has been increasing each year. The number of international nurses who have joined the register has almost doubled from 2016 to 2020.
It is interesting to note that while the number of New Zealand qualified nurses remains consistent, there appears to be an increased reliance on international sources to sustain the nursing workforce. Applications for registration have nearly doubled in the past three years (NCNZ, 2022). Most international applicants have been directed to undertake a CAP.

Otago Polytechnic is one of 19 providers of CAPs that have been accredited by the NCNZ (NCNZ, 2022). While there is no national curriculum, programmes are guided by the NCNZ’s Standards for Competence Assessment Programmes (NCNZ, 2008). Under Criteria 1.1 of the Standards, the content is required to include: Treaty of Waitangi, cultural safety, legislation impacting on the practice of nurses in New Zealand, and an update of nursing skills and current practice (NCNZ, 2008).

The CAP at Otago Polytechnic has become a stand-alone course and therefore a review of curriculum is timely. There is no New Zealand research into how best to prepare an INQ for professional assessment in New Zealand. A substantial amount of research does exist into the experiences of nurses transitioning both in New Zealand and in other countries (Garner, Conroy, & Bader, 2015).

The NCNZ regulates the registration of nurses in accordance with the Health Practitioner Competence Assurance Act (2003). The Council’s annual report outlines the functions and activities of the Council; its published standards and guidelines represent how nursing education and registration are governed.

Nurses are attracted to work in New Zealand for a variety of reasons. Applications for registration in New Zealand from Indian nurses have doubled between 2016 and 2017 (NCNZ, 2022). Nursing has been seen as a low-status profession in India; little professional
development or protection has been offered to the Indian nurse (Garner, Conroy & Bader, 2015). The major reason for nurse migration is economic advantage in Western countries (Kingma, 2006). For many nurses, salaries in their home countries are inadequate and the desire to migrate arises from an economic motivation with the promise of higher standards of living and better education opportunities for children (Dicicco-Bloom, 2004; O'Connor, 2016).

The internationalization of the New Zealand nursing workforce is controversial. While IQNs bring a wealth of experience and alternative cultural perspectives, their contribution has not been without criticism (O'Connor, 2016). Nevertheless, the aged care sector of New Zealand is heavily reliant on the international nurse workforce. Limitation changes made to Immigration New Zealand policy, as well as increased hiring by district health boards, had the aged care sector anticipating a state of crisis (Longmore, 2021). The New Zealand health workforce is reliant on international nurses’ contribution.

With half the current nurse workforce set to retire by 2035 and the aging generation of older people predicted to flood the healthcare system, the need for international nurses can only increase (Boyd et al., 2011). But what are the experiences of those IQNs who migrate to other countries? Exploration of migrant nurses’ experiences is, unfortunately, not positive (Chun Tie, Birks, & Mills, 2018). Commonly, nurses have identified a lack of transition support, practice expectation conflicts, and prejudice in the workplace from patients and colleagues, as adverse and unexpected conditions.

**Nurse Migration**

Nurses have been on the move for decades. Travel and working abroad was often a drawcard for those choosing to enter nursing. In more recent times, the phenomenon of ‘care-labour migration’ (Yeats 2010) has come under increasing scrutiny, as health workforce demands change (Jones & Sherwood, 2014). Nurses have been the largest occupational group within the global health care workforce and have made up one third of all migrants (OECD, 2021; WHO, 2010). It has become increasingly clear that a global shortfall in nursing numbers is impacting both poor and rich countries – in different ways and for different reasons. Globalisation has meant the world has become increasingly interconnected and, therefore, the ability for nurses to move among countries has become easier. Changes have occurred in Organisation for Economic Cooperation and Development (OECD) countries that have impacted nurse workforce demand: improved income levels, growth in medical technology, advancement of treatment options and population ageing, to name a few (WHO, 2010). While some countries have responded to nursing shortages by increasing their domestic education programmes (e.g., Norway and Switzerland), other countries, such as New Zealand, have become increasingly reliant on international nurse migration as a workforce source (OECD, 2022). The World Health Organisation (WHO) estimates a current nursing shortage of 9 million nurses and midwives (WHO, 2022); a large proportion of this deficit is amongst poorer countries.
Nurse Migration to New Zealand

Nurse migration to New Zealand is a controversial topic. Whilst the NZ nurse workforce is strongly supported by international nurses, some disquiet exists. The New Zealand Nurses Organisation has raised concerns around the proportion of nurses who have been educated outside of New Zealand. In a 2010 article, Leonie Walker asked: how long will members of this workforce remain in NZ?, should NZ students be concerned about being able to attain a nursing position?, is the NZ nurse workforce prepared to work alongside so many international nurses?, and how ethical is it to take nurses from struggling countries (Walker, 2008).

Nurses typically migrate from predominantly developing countries to wealthier ‘first world’ health care systems. The Philippines is the largest ‘donor’ country, closely followed by India (Lie, Nie & Li, 2014). This correlates with the New Zealand cohort of IQNs, with 42% identified as coming from the Philippines and 26% from India (NCNZ, 2020). However, political and epidemiological changes in the Philippines have seen a significant reduction in the number of nurses emigrating to New Zealand (NCNZ, 2022).

Several factors contribute to the movement of nurses around the world. Push factors are emigration forces within the home country that impact a nurse’s decision to move. These might include poor salary, limited or no career or professional development opportunities, inadequate work-related resources, unstable work and living conditions (including political), and a lack of personal safety (Li, Nie, & Li, 2014). The predominant causes for nurses to migrate are regarded as better wages, better professional development, and freedom from political risk (WHO, 2018). Correspondingly, receiving countries, seeking to attract nurse migrants, offer pull factors that relate to these issues, often offering higher wages, more advanced clinical contexts, professional development pathways, greater professional respect, and safer work and life environments. A number of these push-pull factors will be seen in the participant data later (Li, Nie & Li, 2014; Trines, 2018).

Pull factors are influenced by changing conditions within countries. In New Zealand, 50% of the present nurse workforce will retire by 2035 (O’Connor, 2016). Similar rates of nurse retirement are predicted for the United States and United Kingdom (Trines, 2018). Additional issues influencing the force to attract or pull nurses across the world include an ageing population, decreasing interest in nursing as a career, disenchantment and exiting of nurses due to working conditions, and inadequate funding of health care services (Trines, 2018).

In 2021, 1,865 graduates from New Zealand nurse education programmes joined the register while 1,819 nurses educated outside of New Zealand joined (NCNZ, 2022). This proportion reflects the significance international nurses have in maintaining the New Zealand workforce. In 2021, there were 59,803 registered nurses in New Zealand; one third of these were educated outside New Zealand (NCNZ, 2022).
International Nurses’ Experiences

But what are the experiences of those IQNs who migrate to other countries? Exploration has shown migrant nurses’ experiences are, unfortunately, not positive (Chun Tie, Birks, & Mills, 2018). Commonly, nurses identified a lack of transition support, practice expectation conflicts, and prejudice in the workplace from patients and colleagues as adverse and unexpected conditions.

A number of issues are commonly found in the literature around the migrant nurses’ beginning experiences. Language and communication have been cited as major challenges, often exacerbating fear and mental exhaustion as nurses work amidst a language that is not their first (Jenkins & Huntingdon, 2016). A lack of assertiveness and unfamiliarity with delegation have been found to contribute to adjustment stress for nurses working in the operating theatre environment (Cummins, 2009).

Another form of stress for IQNs can be navigating the differences in non-verbal communication, such as eye-contact and smiling. Gestures involving head movement and smiling can convey different meanings and misinterpretation can occur as nurses communicate with each other and patients from a new country (Primeau, Champagne & Lavoie-Tremblay, 2014).

Some IQNs have reported how nurse colleagues have failed to recognise and value their education and previous clinical work experience; for some, this has led to a sense of resentment and even self-doubt (Primeau, Champagne & Lavoie-Tremblay, 2014). Nurses may have felt they are distanced by colleagues, or not valued or trusted, and therefore alienated (Magnusdottir, 2015, as cited in Newton, Pillay & Higginbottom, 2011).

Social dissonance was described by Xu, Gutierrez and Kim (2008, as cited in Newton, Pillay & Higginbottom, 2011) as a state of severe anxiety brought about from the struggle to learn to assimilate in a new country. A lack of progress felt in adjusting to a new practice environment, along with a perceived lack of support, is described by Sochan and Singh as cultural disillusionment (2007, as cited in Newton, Pillay & Higginbottom, 2011).

Isolation

In a 2016 study, Jenkins and Huntingdon identified three aspects of transition that IQNs found challenging when commencing work as a registered nurse in New Zealand. Firstly, the physical transition, nurses discussed the difficulties in being physically separated from family and culture and climactic adjustment. Loneliness and isolation were reported along with the physical struggle with cooler weather. Again, the inability to freely communicate and a lack of confidence from limited vocabulary contributed to feelings of cultural isolation. Secondly, social isolation was described as a loss of extended networks of family and friend and the
feelings associated with having limited friends and family members in the new country. The loss of these important relationships was somewhat compensated through new friendships forged during the CAP process. And finally, professional transition, the impact of moving from a clinical workplace where one felt familiar, valued and comfortable, to one where previous experience was not necessarily acknowledged, with disorientation due to different environment and systems, and, in the case of working in aged care, a loss of acute caring nursing skills (Jenkins & Huntingdon, 2016).

In an important metanalysis of the lived experiences of migrating Asian nurses, seminal nurse-migration researcher Yu Xu identified four key themes in the research literature of the time: a.) Communication as a daunting challenge; b.) Differences in nursing practice; c.) Marginalisation, discrimination and exploitation; d.) Cultural differences and cultural displacement (Xu, 2012). These phenomena correlated with the issues identified earlier in this section and expanded the understanding of them.

**Communication**
The challenge of communication in the clinical setting was worsened by an unfamiliarity with new and different accents and idiomatic language that was a barrier to communication integration. This could impact the interaction not only with professional colleagues, but with patients and families also, affecting feelings of satisfaction from both the nurse and those receiving care. The telephone was also a major challenge for some – fear of misunderstanding or error from miscommunication led to a reluctance to use the telephone. While accent differences may make communication challenging, some nurses reported feeling discriminated against due to the sound of their spoken voice (Xu, 2012). This contributed to a feeling of ‘otherness’ and alienation as mentioned earlier. Xu (2012) wrote of the domino effect of communication deficiency. This was how the fear of speaking up and making communication errors led to a reluctance to communicate from a lack of confidence, leading to feelings of embarrassment and inadequacy.

**Differences in nursing practice**
Differences in nursing practice have been reported particularly in areas of role and scope of practice. For example, dealing with significantly heavier patients, the lack of family support for patients, and the technical and ethical-legal expectations in the new health care environment (Viken et al., 2018). Perhaps it was in this area that most migrant nurses anticipated struggling with difference.

**Marginalisation**
A sense of ‘otherness’ arises through marginalisation, discrimination, and exploitation, a feeling of not quite belonging – feeling disenfranchised and excluded from opportunities offered to local nurses. These are regrettable findings that have been identified in several studies (Allan, Cowie & Smith, 2009; Magnusdottir, 2005; Viken, Solum & Lyberg, 2018). Xu
(2012) found a number of migrant nurses reported that they were treated differently by being given heavier work assignments, undesirable shift patterns, and experiencing bullying and sexual harassment.

**Cultural differences**

Xu’s fourth theme derived from his metanalysis was cultural differences and displacement. This related to the concepts mentioned earlier of cultural dissonance and disillusionment. Migrant nurses’ own cultural values, beliefs and norms may ‘clash’ with those of the host country; an allegory of the mixing of oil and water was reported as representing the challenge some migrant nurses face (Xu, 2012). Xu discussed how many Asian nurses perceived a lack of respect for the elderly through abandonment and disrespectful communication (e.g., calling them by their first names). Many IQNs begin their careers in New Zealand working in the aged care sector.

As a migrant Chinese nurse himself, Xu had an unique position to explore the socialization background of Asian nurses. He wrote about the collectivist versus individualist conflict that Asian nurses feel and the importance of hierarchy in community (Xu, 2012). In addition, many Asian nurses found it difficult to say ‘No’ to those senior to them or in positions of authority. This often led to additional workloads and miscommunication in the Western workplace and provided insight into the impact that socialization has on migrant nurse behaviour (Xu, 2012).

In New Zealand, IQNs have also reported discrimination, belittlement, bullying and poor workplace conditions (Walker, 2008). In a study of IQNs working in aged care in New Zealand, aspects of transition were identified: physical, social and professional (Jenkins & Huntingdon, 2016).

**Maslow and the Hierarchy of Needs**

Migrating nurses, like all humans, have needs that relate to the unique experience of seeking to work as a professional in a different cultural context. Within the realm of humanistic psychology, the study of motivation has offered insight into the understanding of human needs and how behaviour is influenced by the pursuit of meeting these needs (Shahrawat & Shahrawat, 2017). In his seminal work, Motivation and Personality, Abraham Maslow (1954) proposed a human needs theory that identified five categories of needs that applied to people – these categories were structured in a hierarchy that represented the scaffold upon which the person is motivated to climb, leading to motivation (and demotivation). The five categories consist of:

1.) **Physiological needs**: critical requirements for life to continue including water, nutrition, air, and sleep.

2.) **Security needs**: a more psychological phenomenon where the person is concerned about threats to self and others. These may be development stage-related or situational. Threats may include physical harm, loss of employment, income, home,
resources, health and others. (These first two levels of needs were regarded as Basic Needs).

3.) Love and belonging: Maslow saw that once a person’s physiological, basic needs are met, and they are feeling safe, and at ease, they may experience a longing for others. This may be in the form of friendships, family, intimate relationships and a desire to feel loved and connected with others.

4.) Esteem needs: A person seeks respect, recognition, a good reputation, and appreciation. The other part to his level of needs is self-respect; a person needs to be able to held in positive regard, and be respected for who they are. When this need is met, the person holds feelings of self-confidence, adequacy, capability, strength and worth. The need for love and belonging and esteem were regarded as Psychological Needs.

5.) At the highest level, is the need for self-fulfillment. Self-actualisation is the ultimate level of being – a place of arrival that one arrives at, having been motivated to satisfy the previous physiological and psychological needs. To be self-actualised is to have reached the point where one is able to be who one is meant to be. Maslow strove to adequately define this concept, but found that self-actualised people were in full use of their abilities and potentialities, were fulfilled in themselves; they had an efficient perception of their reality, accepting those around them as well as themselves – they were spontaneous and outward looking, seeing themselves engaged in the world, while also autonomous (Maslow, 1954). It has been proposed that self-actualisation amongst nurses may be seen as demonstrating behaviours of critical reflection that optimise the care of patients and their families (Freitas & Leonard, 2011).

Figure 2
Maslow’s Hierarchy of Needs. (Chiquo, C., Wikimedia Commons, https://creativecommons.org/licenses/by-sa/4.0)

Maslow’s theory has remained popular in the social sciences, as well as in business management (Fallatah & Syed, 2018). A number of studies involving the needs of nurses and nursing students have drawn upon Maslow, indicating the relevance that this particular
framework has for nurses and understanding them as a professional group (Carpenito-Moyet, 2003; Freitas & Leonard, 2011; Kim & Shin, 2020). This strengthens the relevance of this historical perspective of human motivation and to contemporary nursing issues.

Connections have been made between Maslow’s concept of human needs and immigration (Adler, 1977; Nicholson-Lord, 2004). Wherever a migrant’s level of needs may sit on the classical Maslow hierarchy, the process of migration inherently puts downward pressure upon the person, as they are faced with having to address issues of housing, food, safety and self-respect again as they transition in to new contexts (Adler, 1977). The journey of disruption and crisis that migrants experience can be understood through the lens of an holistic framework such as Maslow’s Hierarchy of Needs.

Maslow’s theory of human needs, while criticized for being somewhat obscure (Shahrawat & Shahrawat, 2017), has been influential in the development of later theories of needs and motivation (Fallatah & Syed, 2018). Herzberg’s Motivation-Hygiene theory, Adlerfer’s ERG theory and McGregor’s X and Y theories contain concepts that can be seen to have been drawn directly from the hierarchy of Maslow (Brown & Cullen, 2006).

Criticism and Relevance
Maslow’s theory has remained popular due to its simplicity and ability to be easily applied. However, one major criticism made of this approach has been made by Hofstede (1984) around the transcultural applicability of the model to non-western countries. Hofstede asserted that the explanation of human needs did not adequately address the cultural needs of people, particularly those from collectivist societies (1984). This criticism has been supported by other authors (Fallatah & Syed, 2018; Gambrel & Cianci, 2003; Noltemeyer et al., 2021), and is a relevant criticism given the present study was primarily looking at the experience of nurses from collectivist, non-Western societies.

Other limitations cited have been around Maslow’s notion that the greater the deprivation of a need, the greater its dominance and, therefore, the greater the motivation to meet this need. Earlier studies found this was not necessarily the case when looking at needs around security, social and esteem needs (Berl et al., 1984; Wahba & Bridwell, 1973). Maslow assumed that once a need was gratified, this would activate movement (motivation) up to a higher need (Wahba & Bridwell, 1973). Longitudinal studies, however, did not find evidence to support this explanation of motivation and upwards movement the pursuit of human need gratification (Hall & Nougaim, 1968; Lawler III & Suttle, 1972).

However, despite the criticisms, this is a theory that holds value for better understanding the experiences migrants such as international nurses may be facing. Adler (2019) successfully applied the Maslow model to understanding the migration needs and experience of people moving to Israel. Contemporary studies into the needs of migrants continue to recognise and
utilise the Maslow hierarchy, validating its relevance and usefulness in the study of migration (Gońda et al., 2021; Tahir, 2021; Zainal & Barlas, 2022).
Methodology

The study design for the present enquiry is represented by Figure 4 which summarises the enquiry’s components that will be discussed in this section.

**Figure 3**
*Summary of Research Design (author’s own)*

| Research approach | • Phenomenological  
| Research methodology | • Case Study  
| Research methods | • Survey  
• Semi-structured interview |

**Research Approach**
Phenomenological researchers seek to understand phenomena through examining people’s experience and exploring the meaning they attribute to this experience (Polit & Beck, 2004). Part of my motivation to conduct this research, was to improve the international nurses’ experience through authentically understanding their needs. Descriptive phenomenology is one of two branches of the tradition that is characterised by simply seeking to understand the meaning of the human experience (Polit & Beck, 2004). I was interested in how migrant nurses in New Zealand saw their needs, as I was concerned there was a disparity between the needs the CAP addressed and the actual needs of the learners.

Emancipatory research acknowledges the existence of multiple realities and seeks to learn from and empower marginalised people (Noel, 2016). Similarly, the constructivist paradigm acknowledges the subjective human experience as an important source of truth (Baxter & Jack, 2008). Yin, an advocate of a constructive approach to the case study method, argued that case study is appropriate when *what* and *how* are asked of participants, when behaviour of participants is not to be manipulated, and when context is important (2003, as cited in Baxter & Jack, 2008). I have chosen a case study approach as it allows for the examination of a case or group of people “within a real life and contemporary context using multiple data sources” (Schneider, Elliott, LoBiondo-Wood & Haber, 2004, p. 35).

This disparity concerned me and prompted me to give a voice to the migrant nurses who came through the CAP. The NCNZ, as the regulator of nursing practice and registration has significant power in determining how CAPs will run. It is important to consider one’s stance towards phenomena, as this inevitably influences the approach and focus of the inquiry (Savin-Baden & Major, 2013). Having worked with international nurses across my career of
more than 20 years, I believed that Western nursing groups can seem more powerful, dominant and appear to discount the perspective of nurses from other nationalities and ethnic backgrounds. I especially noticed this when working in an American hospital in Saudi Arabia, where the dominant nursing system was Western-based and nurses from non-Western countries needed to ‘conform.’

In my initial reflection and planning stages of this project, I was aware of my motivation to empower international nurses in my own country by giving them a voice. When had they ever been asked what their needs were as they entered the nursing profession in New Zealand? And so, there became an emancipatory dimension to my project – I sought to both empower the nurses and free them from assumption and potential neglect. I was interested in the assumptions that underpinned emancipatory research: that multiple realities exist, and that discovery of knowledge should not just come from the dominant group (Groat & Wang 2001; Guba & Lincoln 2005, as cited in Noel, 2016). Emancipatory research seeks to empower the participants who otherwise have been seen as disadvantaged (Noel, 2016). While not the main purpose, this project was influenced by emancipatory philosophy, as it sought to understand the needs of a specific group of people: international nurses migrating to New Zealand. By exploring the views of the nurses themselves, I believed this would empower this group by giving them a voice to help shape the way they are introduced to nursing in New Zealand and prepared for professional assessment. International nurses are a vulnerable, marginalised group who struggle to have a voice in the assessment process (Hernandez, 2018). The nurses and their needs as migrating applicants for professional registration became ‘the case.’

**Research Methodology**

Case study research is a method of inquiry often found in the social sciences; it is an appropriate methodology to use for this study. It is concerned with understanding a case by asking descriptive questions; power and control does not lie with the researcher, and its focus is on the here-and-now (Yin, 2014). Choosing case study methodology, as a beginner researcher, enabled me to focus my information gathering on a particular group: international nurses coming to, and working in, New Zealand. It allowed me to use more than one method to collect information: questionnaire and semi-structured interviews. I wanted to know more about internationally qualified nurses’ experiences and be able to describe what their needs were.

Other features of the case study methodology were appealing (Yin, 2014). Using an holistic lens such as the multi-faceted Maslow Hierarchy of Needs, there were going to be a variety of points of interest: physical, social, spiritual, and psychological. The case study approach manages to capture information from multiple aspects, without limiting the scope of inquiry to only one or two variables. Triangulation from multiple data sources contributes to the validity of the study. The present study examined two sources of data with the anticipation
of further study of a third group. I suspected that the current CAP was based on organisational and regulatory assumptions in the assessment of professional competence. I wanted to employ a methodology that would allow me to use a theory of needs hierarchy to better understand the dimensions of the migrating nurse. Case study methodology allowed data collection methods to be selected based on the theoretical questions.

Research Methods
There were two phases to the data collection: a questionnaire administered to Group A during their first week in class at Otago Polytechnic, and semi-structured interviews conducted with Group B participants.

Group A: Survey
The survey method allowed for anonymous responses without interference from the presence of the investigator (O'Leary, 2014). Information gained from this subject group provided understanding of the “newly arrived” international nurse. Maslow’s Hierarchy of Needs was a reference point for the formulation of the survey questions. This framework of needs is widely accepted as a holistic model of the physiological, psychological and sociological needs of a person. It added strength to the holism that the question set sought to represent. A 17-item online survey was created and piloted on colleagues (see Appendix G). Piloting is where a practice or ‘dummy run’ of the interview process is conducted followed by reflection and adjustment to better understand and promote the authenticity of the data (O'Leary, 2014). Feedback on style and focus of questions was received, which led to editing and adjustment of items in the final survey.

The survey was administered by Organisational Research, a separate department within Otago Polytechnic, so as to distance myself as much as possible from the participants. This was important given my dual roles of investigator and CAP leader. The survey was sent out to participants at the outset of a CAP at Otago Polytechnic with a total of 22 candidates responding (100% response rate). Data was made available for analysis once the participants had completed their CAP and had received their registration.

Analysis
Quantitative data from close-ended questions were tabulated and presented in graphic form to aid understanding of characteristics of the participants. This was to facilitate consideration of information in terms of time since graduation, number of countries previously worked and length of time in New Zealand. Responses were considered in terms of narrative or qualitative data and therefore, were arranged in tabular form then further analysed for proportion and representation of the group in the ‘case’. Responses to open-ended questions were analysed for key words which facilitated the identification of themes. Appendix I represents an example of how theme were identified. Commonly mentioned concepts were recognised and topical
connections considered as major themes were established. Frequency of occurrence aided in the building of themes from the analysis.

A number of the survey questions were open ended, widening the potential for responses from the participants. Following, is an example of the responses obtained from the question that explored differences in nursing roles and practice:

Table 2.  
Analysis Table For Question 6 from Participant Group A

<table>
<thead>
<tr>
<th>Themes of difference identified</th>
<th>Participant Responses</th>
</tr>
</thead>
</table>
| Responsibility, autonomy, scope | Here in New Zealand the nurse's scope of practice is wider compared to my country (P.22)  
the main subjects of the care when compared to the place I worked where doctors play a vital role in the diagnosis and prognosis of the patient. Nothing more, we nurses have the opportunity to assess and take actions according to the patient’s needs(Freedom for execution). (P.20)  
The nursing responsibility is wider than in our country. (P.1)  
New Zealand registered nurses holds more responsibilities than the country which i work . (P.19)  
Here in New Zealand the nurse's scope of practice is wider compared to my country (P.22) |
| Communication | The nursing responsibility is wider than in our country. (P.3)  
Maybe the first difficulty that foreign students is facing is language barrier. I admit that sometimes, I don’t exactly get what other nationalities are telling. But I know I need to practice by myself, to learn and face my soft points. I need to practice and talk to the locals, watch foreign movies in order for me to practice my listening skills as well. (P.9)  
In New Zealand ,nurses are providing high quality care to patients.  
Maintaining therapeutic relationship with patients. (P.15) |
| Skills | The different medications that are usually administered, the different practicea and its procedures would surely differ. (P.5)  
I think it will be about the scope of practice based on assessed skills and qualification. In my country, RN is allowed by many facilities to perform procedure even when you are not trained to do so such as cannulating or starting IV line even the nurse has no IV certificate or training. While in NZ, it is not allowed since the council is very strict and gives more emphasy to health consumer safety. (P.10)  
Most of the practises here are different from India (P.18)  
...the nurses are the main subjects of the care when compared to the place I worked where doctors play a vital role in the diagnosis and prognosis of the patient. Nothing more, we nurses have the opportunity to assess and take actions according to the patient's needs(Freedom for execution). (P.20) |
Table 2. shows how responses were grouped to identify common ideas expressed, contributing to the formation of themes.

**Group B: Semi-Structured Interviews**

One of the aims of the present study, was to give voice to those who are most involved in the competence assessment process, the nurses themselves. In order to understand their needs, I had to be able to listen to their voices and allow them to teach me. Interviewing is the art of both asking and listening (O'Leary, 2014). I chose this method as it would allow international nurses to reflect back and inform with less limitation and structure. I wanted to explore and better understand what I thought the needs were, but also to discover things I did not know were present in the lived experience of the nurses. Using the semi-structured approach, allowed me to begin my exploration from points of enquiry that were obvious to me, but to allow for story-telling and the free expression of ideas by the participants. I believed I knew about the newly-arrived nurses, but much less about the post-registration experience. Other studies that used the semi-structured approach gathered more information than initially anticipated (Äsbring & Närvänen, 2002, as cited in Polit & Beck, 2004; Gibson, 1998).

A total of 11 questions were devised and piloted on a group of five nurses who were in an earlier iteration of the programme (see Appendix H). Appointments were made with the Group B participants individually and interviews were held and recorded with permission.

**Analysis**

I listened carefully to the participants as they told their stories. Some were more expressive and passionate than others. Some had thought ahead, of how they wished to respond, while others seemed somewhat distracted and were considering the questions for the first time. The interviews were transcribed verbatim by me and then analysed for thematic content (see Appendix J). Transcriptions were searched for repeating concepts or ideas. While consideration was given to the Maslow hierarchy of needs, a deductive process was used to allow for new or unexpected information to come through. For example, it was expected that participants would talk about their needs for accommodation and safety, it was not however expected that participants would mention bias and racism. It was important to keep an open mind to allow whatever information was available to be appreciated from the responses. I attempted to comprehend what the participants were saying, rather than fitting in their words around my presupposed ideas. I sought to link ideas expressed in order to be able to understand broader concepts from their experiences. Appendix J provides an example of how I analysed the responses for key and relevant words and phrases, searching for deeper meaning and connection of ideas amongst the responses. Once I had identified considerable key words, I had several meetings with my supervisor to discuss and reflect on data from the interview, recognising patterns and gaining a deeper understanding of the responses. From this pattern...
analysis, I was able to recognise the key themes that portrayed the responses my analysis of migrant nurse needs.

**Research Question**
The main research question was: *What are the needs of migrating nurses undergoing a process of assessment that leads to professional registration?*

Sub questions, not asked of the participants, but relevant in the consideration of implications from the data included: How effective and relevant is the curriculum of the CAP at Otago Polytechnic; Is the CAP at Otago Polytechnic meeting the needs of the international nurse to transition; and is the content of the CAP preparing the international nurse to deliver nursing care successfully and safely?

**The Participants**

*Group A: Newly Arrived IQNs*

This group of 22 international nurses were enrolled in the CAP at Otago Polytechnic. During the introduction to the CAP, the present study was outlined to the enrolled students by a gate-keeper – a nurse lecturer who was not involved in the CAP. The potential participants were assured of how anonymity will be protected and how the data will collected by a department separate from the School of Nursing.

Inclusion criteria were:

- International registered nurses seeking registration in New Zealand, and
- Who were enrolled in the CAP at Otago Polytechnic.

Exclusion criteria were:

- Nurses already holding New Zealand registration, or
- New Zealand educated nurses.
Group A represented nurses at the very beginning of the CAP whose needs would be different to those already assimilated into the current context. Nurses in the group came from either the Philippines or India.

**Figure 4**
*Group A: Country and Gender*

![Bar chart showing the number of Group A participants by country of origin and gender.](chart)

**Group B: IQNs with New Zealand Registration**

This group was made up of international nurses who had at least one-year post-registration experience in New Zealand. They had been engaged in continuous employment and may have been working in the hospital setting or in the residential aged care sector.

Recruitment advertisements were placed in staffrooms in hospital areas, on the hospital staff intranet, and on a local IQN Facebook page; hospital nurse educators were asked to facilitate recruitment.

**Inclusion criteria:**
- IQNs who have completed a CAP
- Held NZ registration for at least one year; and
- Currently employed as a registered nurse in Otago.

**Exclusion criteria:**
- IQNs with less than one year experience after gaining New Zealand registration;
- New Zealand educated registered nurses; or
- Employed as a registered nurse outside Otago.

Two groups would allow comparison to be made between the needs of naïve arrivals and experienced, acculturated nurses.
Ethical Considerations

Potential sources of harm were considered in the methodology of data collection. It was acknowledged that participants who were new to New Zealand were vulnerable to coercion and communication barriers. An application for ethical approval was submitted to the Otago Polytechnic ethics committee and was approved (see Appendix C). Approval was also provided by the Otago Polytechnic Kaitohutohu office (see Appendix D). The enquiry was also supported by the Head of School, Nursing (see Appendix E.)

Otago Polytechnic follows the Education (Pastoral Care of Tertiary and International Learners) Code of Practice 2016/2021 and is required to provide a safe and supportive environment for study. The degree of vulnerability was carefully considered. Newly arrived migrant nurses were identified as a vulnerable group. They were in a state of cultural disorientation as they came to terms with their new contexts: country, professional institution, culture and language. They may have been inexperienced in research participation and may have felt obliged to comply and participate.

It was important to acknowledge the power differential between my role as the course coordinator, responsible for the assessment of the candidates for registration, and their seemingly subordinate role as student. It was important for the potential participants to be assured that their involvement in the study, and their responses, would have no bearing on the outcome of their programme. To this end, an independent collaborator was appointed who introduced the study to the students on their first day, explaining the aim and intentions of the study. She explained how anonymity would be protected using an electronic survey system that was separate from the School of Nursing and that their responses would only be released once they had completed their programme.
She informed the candidates of how they could withdraw from the study at any time and responses would be deleted. The Polytechnic’s International Student Support service was also informed of the study and the nurses were encouraged to discuss any concerns with the related support person from this service.

Group B participants were seen to be less vulnerable as they had already been through the professional assessment process, had received their registration and had no connection with the CAP. Permission was also sought from the Chief Nurse of the Southern District Health Board as well as managers of aged residential care facilities who employed participants. Ethical approval was also granted by the Southern District Health Board to involve employees as participants. While not formally necessary, this request for approval opened a collaborative relationship between Otago Polytechnic and the Chief Nurse’s office which was to later develop and lead to new interest in the area of international nurse needs within the District Health Board. Mechanisms to protect the rights and privacy of participants were explained to Group B participants who were recruited using advertisements in clinical workplaces in all wards of the local hospital, in most aged residential care facilities and on social media.

**Socio-Cultural Considerations**

It was important to consider the cultural differences in the student-teacher dynamic in Asian and Southeast Asian cultures compared to in New Zealand. Anecdotally, Asian students hold the role of teacher in unconditional high esteem. There is a risk that participants may seek to give “socially-desirable responses” to please the lecturer. This potential effect was addressed by a comprehensive explanation of the purpose of the study and emphasis on it being important to receive and welcome both positive and negative comments to improve the programme for subsequent candidates. The recruitment explanation focused on the aim to give IQNs a voice as migrant nurses, to learn from listening and thereby benefit future nurses enrolled in the CAP Programme.

In this section, I have examined the information collection around two different but related groups. In Group A, new arrivals to New Zealand, I utilised the survey method to gather information in a way that was less intrusive and therefore, less likely to contribute to test-bias. The survey method allowed for the impersonal collection of information amongst conditions that would allow participants to respond freely. A different approach was used for the New Zealand experienced nurses. The semi-structured interview process allowed for a more intimate yet open environment for the participants to share their experiences and perspectives. While some respondents were more formulaic in their responses, others took the opportunity to realise more personal motivations to share information about the lived experience of the migrant nurse. In the following section, I will present the outcomes of this mixed-method approach, sharing the stories of the nurses and discussing how these stories were analysed in order to appreciate the needs of the migrant nurse.
Findings

Group A: Newly Arrived Internationally Qualified Nurses

Figure 6  
Years Since Graduation of Group A

Twenty-two newly arrived internationally qualified nurses (IQNs) responded to a questionnaire survey. Most of the nurses were in the early stage of their careers. The minimum requirement to enter the CAP is at least two-years clinical experience. While the participant group had met the requirements for entry, they did not necessarily have a substantial amount of experience; only 14% of participants had senior level of experience. Therefore, most of the nurses could be seen as early-career migrants.

Length of Time in New Zealand
All participants in the survey had less than six months experience of being in New Zealand. In fact, all participants in the group had arrived in Dunedin just ahead of the commencement of the course they were enrolled in. Other CAP providers only enrol IQNs who have been in New Zealand for at least six months. Otago Polytechnic does not have this requirement and this group reflects the predominance of newly arrived migrant nurses.

Health Care Assistant Experience
Participants were asked whether they had previously worked in a healthcare assistant role. Several migrating nurses will often work as health care assistants while waiting acceptance in a CAP. This group were all new arrivals and therefore no one had previously worked in New Zealand.
International nurses have often worked in more than one country before migrating to New Zealand. While half the IQN group came from India, a similar proportion originated in the Philippines. This reflects a growing trend in the increasing proportion of Indian nurse migrants as compared to those from the Philippines, the previous dominant source country. Interestingly, one third of the group had previously worked in the Middle East. This is an area of the world dependent on the international nurse workforce. Only one member of the sample had worked in Europe (Belgium) - an Indian-trained registered nurse.
The participants had all chosen to come to New Zealand specifically. Seven key themes were found amongst their reasons for emigration to New Zealand. There was a strong theme of preference; responses often began with, “I chose to come to NZ...” “I decided to come to New Zealand...” Responses referred to desirable characteristics of the country: “First of all, New Zealand is a good place to settle, and I heard that vacancies are aplenty for nurses.” (Participant 11).

Reasons given were around professional, social and financial differences between the country of origin and New Zealand. The most cited reasons related to family and career. Clearly, participants valued family and it was important to be able to raise a family under better conditions than their country of origin: “New Zealand provides a variety of benefits for migrant people like education and schooling, safety, health care facilities, permanent residency and so on” (Participant 6). Nurses sought opportunities to learn and develop their careers. Improving their professional practice was important: “Career development. I wish to broaden my knowledge with the nursing profession. I want to become a better nurse, not just for myself, but also for my family” (Participant 5). Salary difference was evident, and nurses recognised the greater earning potential to be found in New Zealand. Nurses hoped to find a greater respect and professional recognition as a registered nurse. Participant 7 reported, “Here people give respect to my profession, and it is well paid.” Not all reasons centred around vocational issues. New Zealand was a new country to explore, and several nurses referred to their interest in exploring the environment and the friendly people. A large group reflected the opportunities in lifestyle, health, education, and migration they were hoping to find in New Zealand. Safety was a significant issue for many in the group and some reported an
understanding that the country they were coming to was more safe and secure. Participant 7 said New Zealand was “a safe place to live with family.”

Differences in Nursing Role and Practice
Five key areas of anticipated difference between countries were reported. Several nurses felt that they would have a wider scope of practice and a higher level of responsibility practising in New Zealand. New Zealand registered nurses might perform functions and assessments that would have been performed by medical staff ‘back home.’ Others observed they would need to take on a higher level of professional responsibility when working in New Zealand.

Differences in language and communication styles posed a barrier to the international nurse: “I admit that sometimes, I don’t exactly get what other nationalities are telling. But I know I need to practice by myself, to learn and face my soft points. I need to practice and talk to the locals, watch foreign movies in order for me to practice my listening skills as well” (Participant 9). Several respondents recognised an interpersonal difference in nursing practice: the therapeutic relationship.

Nurses noted that many of the procedures performed in clinical practice have different requirements in competence. Some referred to the notion that doctors perform tasks ‘back home’ that registered nurses perform in New Zealand. Others observed that many sophisticated skills in their previous practice had not been assessed but would need to be assessed before being able to articulate them in a New Zealand context.

Figure 9
Differences Related to Nursing Practice (author’s own)

Legal and ethical differences were noted amongst responses. Patients’ rights and the regulation of practice were a key area commented on by one participant: “Back where I trained, rights of the patients are not upheld that much, (maybe due to low health literacy) as well as the standard of practice, a lot of incidents go unreported. Here, patient rights are really important” (Participant 16).
Cultural differences were a fifth area, commented on by the IQNs. Several respondents noted the concept of cultural safety, the ability to provide care that acknowledges a person’s culture and is found to be acceptable to the receiver of care. Respondents noted the importance of culture in New Zealand and that they would be expected to consider culture when perhaps it had not been expected of them previously.

Figure 10:
Preferred Ways Of Assessing Competence

Nurses in this group had recently arrived into the CAP. They were asked about their preferences for how they are assessed. They were not aware at this stage of how they would be assessed necessarily. Clearly, the preference (and perhaps expectation) was that they would be observed and provided with feedback. The importance of a behavioural component to assessment was noted. Written forms of assessment were preferred to a lesser extent, with acknowledgement of the utility of a written exam but with nearly half preferring an academic assignment. Role play was the least desirable method of assessment, suggesting perhaps a preference for real-life clinical contexts for demonstrating practice.

Content Expected in a Competence Assessment Programme
This was a key question that sought to identify what the international nurses themselves felt should be in the curriculum. Nurses expected to be provided with an orientation to the content of the programme as a whole and to the expectations on their performance during the six-week period. Many of their responses centred around nursing skills, providing specific examples regarding clinical measurements and interpersonal communication. Nursing knowledge was referenced, including areas such as infection control, quality of care, paediatric nursing, and the New Zealand health care system. Professional responsibilities and the regulation of nursing were expected, including scope of practice, nursing roles, and codes.
of ethics and conduct. Participants recognised that culture was a significant aspect of nursing in New Zealand and wanted to look at the culture of New Zealand, norms, rules, and beliefs, including Māori culture. And finally, healthcare law was noted amongst the respondents as being important.

Some participants’ responses matched the current content in the Otago programme: “wound assessment; moving and handling; use of equipment; health assessment; interpersonal communication; I found that the common units of some diagnostic tests and vital parameters are different from what I have practiced so far. Units for temperature (Celsius) and blood glucose are the crowning examples to the point” (Participant 20). Others referred to topics that were not currently included: “I would like to know more about the different departments associated in the health care system” (Participant 13); “Probably a brief overview of how New Zealand health care system works” (Participant 21).

**Pre-Readings**

CAP participants are sent a collection of documents ahead of commencing the course. These include professional codes, regulations, and online courses that relate to nursing practice. Two-thirds of the participants had read and completed all the pre-reading material. Most of the remainder had partially completed the material, with less than 10% indicating they had not looked at it before commencing the programme in New Zealand.

**Ways of Learning**

![Preferred Ways of Learning](image)

Participants were asked about their preferred ways of learning. The modes suggested were: lectures, group discussions, practical demonstrations, practical exercises, online resources, role plays and games. The most popular mode was the traditional lecture where the teacher stands at the front and delivers information directly. Role play, again, as noticed earlier, was
only popular with half the group. Least popular, surprisingly, was learning from guest speakers.

**Length of Course**

Figure 12

Preference in Course Duration

Competence assessment programmes vary in distribution of time across the theoretical and practical components. More than two-thirds of the group surveyed were satisfied with the present two-week timeframe for theoretical revision. Another group would have liked an extra week on theory.

The current clinical component of the CAP is six weeks long; half of the group were happy with this duration. However, almost half of the group believed that less time could be allocated to the clinical experience and that four weeks was sufficient.

**Critical Thinking**

Nursing practice, roles and responsibilities vary from country to country. While most nursing education curricula make reference to *critical thinking*, the interpretation of and value placed upon this form of clinical reasoning is also variable. Survey participants were asked about their understanding of this term.
A number of themes were apparent in examining the nurses’ ideas about the concept of critical thinking.

Some nurses felt that the use of critical thinking was demonstrated in the characteristics of a nurse: “Being composed or relaxed and able to perform well or to provide solution to sophisticated events even under pressure” (Participant 10). A critically thinking nurse is a successful nurse and one who acts wisely, keeping an open mind and being proactive in their practice. Other nurses referred to quality of care – keeping patients safe and avoiding harm: “to form a judgement for the better health and safety of the clients” (Participant 15). Several nurses considered emergency care and how critical thinking was characterised by speed of thinking and patient safety: “One must have logical/critical thinking to avoid any unnecessary inflictions that can cause harm to health consumers, specifically when an uncalled issue arises, during emergency situations” (Participant 1).

Many responses related to cognition and how nurses should think. Some felt that when critically thinking, the nurse should be able to draw upon past clinical experience, use a precise and logical way of reasoning, think objectively and use analysis to come to a clinical judgment, as expressed by Participant 8: “Critical thinking is the ability of the nurse to act accordingly to any given scenario in actual workplaces that results from quick, objective, and precise thoughts, judgement, and analysis.”

Group A represented the perspective of international nurse who had recently arrived in New Zealand. They were able to reflect their expectations and content they felt was important to
them, ahead of their engagement with the New Zealand health care system. In the next section,
Group B, international nurses with experience of working in New Zealand, will provide
information based on experience and hindsight, having already passed through the CAP
process years previously and providing responses informed from their New Zealand
experience.
**Group B: Internationally Qualified Nurses with NZ Experience**

**Learning**

Education is a key component for a nurse embarking on a journey of professional transition. It equips the professional to be able to perform at the required standard and empowers them to participate in the adjustment process. Standard One of the Competence Assessment Programme Standards requires accredited Programmes to have “theory and related practice experience to enable students to demonstrate their ability to meet the NCNZ Competencies for their scope of practice” (NCNZ, 2008). The theoretical component of the programme serves to prepare the candidate for the process of professional assessment, as well as equip them with knowledge and skills to be able to practice nursing safely in New Zealand. Learning was a theme that featured in the interviews of the second group of nurses who reflected back on their previous experience of the CAP.

**Previous Educational Experiences**

It became clear early on, that the nurses were conscious of the CAP involving a different style of teaching and learning from what they were previously used to. When asked about their teaching style preferences, they were more familiar with the didactic, lecturing style that was common in their home countries: “[In India] ... there is only one-way lecturing with the teacher just explaining, using the board. There is no two-way interactions happening there” (Participant C).

Differences were noticed in the nurse-learner relationship. Some nurses seem to struggle or are possibly feeling intimidated when they first start in the classes. This is evidenced by ‘quietness,’ a reluctance to speak and participate in discussions. This may be linked to respect, a sub-theme that appeared in several parts of the interviews. In the learning environment, respect for the teacher is clearly more prominent in their previous education systems. One participant commented, “Back home, first there is Mother, then Father followed by Teacher, then God ... this is the way it is for us” (Participant F). Some nurse educators, who are not familiar with working with international learners, find it perplexing why CAP nurses are less vocal and participative in classroom sessions yet display enormous respect to the lecturer.

Respect for the teacher and familiarity with a different teacher-student relationship provides understanding on, a.) why classroom behaviour is observed differently, and b.) why the ‘Western’ classroom culture may not be appropriate.

This reluctance to ‘bother’ the teacher may account for the noticeably fewer questions asked in class. However, respect and the resultant deference can impact on patient safety in the clinical setting. If a nurse’s socialisation and obligation to prioritise respect over more direct communication impedes their actions in situations of patient risk, this may make them less...
competent to represent the needs of a vulnerable health care consumer. This will be discussed further when the major theme of communication is discussed.

Some nurses did not see the value of classroom discussions saying, “I feel a lot of time is wasted in group work when you can’t really come up with something” (Participant E); and “It’s not the culture – the way we were taught nursing ... we always concentrated on books and exams” (Participant J).

This is something that I have noticed in classrooms, where candidates appear more at ease and relaxed when the lecturer is doing all the communicating and the nurses are able to remain silent and listen. An explanation was offered by Participant J: “When you are a student, especially when you have an Indian education system, being a student, you are not allowed to speak up” (Participant J).

One strategy employed in the classroom, is to have the names of nurses placed in front of them so that the lecturer may directly ask a candidate a question. This Socratic style of interacting can often appear to be stressful for the learner. However, it does provide the nurse an opportunity to discover their new voice, their CAP voice, a communication development that pervades the theoretical weeks of the programme.

Candidates acknowledged the differences in classroom culture and felt it was something their own countries should adopt in nursing education, as exemplified by Participant C:

> Here we can sit and answer but there, we automatically stand up and answer the questions. Lots of difference with all the culture as well. Even in the class, I still remember that we couldn’t eat or drink in the classrooms but here I have seen students can (Participant C.)

Not everyone was happy with the interactive nature of classroom sessions. A preference for a more traditional lecture-style classroom was expressed by some, for example,

> “I feel a lot of time is wasted in group work when you can’t really come up with something new” (Participant E).

**Distance**

A common subtheme, when looking at responses that addressed the teacher-learner relationship, referred to the difference in distance they perceived between the roles. Examples include,

> The way we are raised up at home, there is a distance between the student and teacher relationship. We will not call the teachers by their names – only Sir or
Madam or Miss. I felt very happy and proud to be here and could relax and sit in the classroom (Participant D); and

There is a big gap that you as our teachers, lecturers, we look high up to you and shouldn’t bother you about this one. (Participant E)

Reflection
Contemporary nursing students in New Zealand are encouraged and required to reflect continuously on their professional and personal selves throughout their three-year academic journey. Reflection is a tool that has become prevalent across the health professions as a way of raising self-awareness and professional development. However, this is another area of educational dissonance for the international nurse. Several participants commented on the difficulty in the reflective writing assignment that is a component of the CAP. Candidates are also required to keep a daily clinical diary during the six-week clinical experience to provide opportunity to develop a greater awareness of self as a therapeutic being. Participant J remarked,

even at school, kids don’t write stories about themselves, about how they feel about things. Because even in nursing, you only think about the patient you are caring for, you never think about yourself. (Participant J)

The consideration and exploration of self seemed extremely difficult and perplexing for nurses, particularly those from Indian backgrounds, as noted by Participant C:

We don’t have any of those kinds of things [reflection] back home. It’s mainly just following the procedures, doing the practical. (Participant C)
One participant felt that the academic requirements around the reflection were less important than perhaps the nurse’s expression of their journey:

*I mean, it’s good to do the reflection, exemplar, and stuff but maybe you don’t have to be so strict, it’s not how you write, and what the tutor wants you to write, it’s more about what you learned and what you did.* (Participant J)

Content
An aim of the present study was to understand the needs of international nurses who migrate to work in the New Zealand health care system. One of the questions in the interview gave nurses an opportunity to look back on what they felt should be in a CAP. As leader of this programme, I have the flexibility to adjust content and respond to changes in clinical contexts. However, I have not, to date, made changes to content based on what the candidates for registration themselves have said.

The NCNZ only loosely prescribes content areas under Criteria 1.1 of the Competence Assessment Programme Standards (NCNZ, 2008, p. 5): “The content is specific to New Zealand and includes: the Treaty of Waitangi, cultural safety, legislation impacting on the practice of nurses in New Zealand, and an update of nursing skills and current practice.” Two respondents mentioned te taha Māori, citing the need to explain te Tiriti o Waitangi and tikaka Māori more. Currently, more than 10% of the course addresses those areas.

Practical knowledge around wound management, drugs, palliative care and management skills were identified as areas nurses needed to know about. Participants said they would like more information about specific wound products and a more specific drug information. Participant A suggested candidates could,

*Make a workbook to find out alternative drug names, they can do a research in there – if they are familiar with the alternate names of the drugs from their country, so they won’t have a very hard time when they come here.* (Participant A)

Communication was an area discussed when asked about preferred content in a course. Several nurses recognised that they needed help with learning how to communicate appropriately within the New Zealand health care system, for example:

*Finding your CAP voice: I think that was centring – being able to communicate themselves very well to doctors, to patients, to their colleagues is I think very important component of the two-weeks. She could have taught us more expressions, armed us with things that we could say.* (Participant F)
This is something that I have noticed in the End-of-Life Care workshop that is a part of the programme; candidates have often said that they do not know what to say to patients who are dying and want to be told the words and phrases to use.

One aspect of communication that is characteristic of the Western approach to nursing is the value and importance placed on therapeutic communication. One respondent commented on the challenge this approach posed to migrating nurses:

*It should be more on the component of communication as an international nurse to the patient – the therapeutic communication – the vocabulary – it's very awkward initially – I was shocked with the patients.* (Participant D)

The importance of legal and ethical aspects of nursing in New Zealand was recognised. A major piece of work candidates need to complete through self-directed learning is the Legal-Ethical Workbook. Respondents acknowledged that while this required a large amount of work, it was essential content. This correlates with the NCNZ requirement that legislation be included in curriculum.

Critical thinking was acknowledged as being an important component. Nurses with relatively low levels of clinical experience may struggle to demonstrate independent critical thinking – it was seen as a valuable part of the course as there is often a wide range of years for post registration experience.

Prefered ways of learning was a sub-theme. Clearly, for some, self-directed learning was a new phenomenon. Coming from more directed, hierarchical and proscribed education systems, pedagogical approaches in New Zealand were a surprise. Collaborative learning, reflection and learner-directed enquiry were unfamiliar with many, yet they made reference to the benefit they could see in these approaches to teaching and learning: *If you are taught in the classroom you tend to forget but when you do your own research to find your answers, you never forget it* (Participant A).

**Essential Content**

Participants were asked about what areas they felt were essential content in a CAP course. Palliative care, drug calculations and legal and ethical issues in New Zealand were identified. These concepts are currently included in the programme but is important to recognise that programme graduates saw these topics as “essential.” Participant H reported they would have liked to have management skills included.

Direction and delegation were also seen as an essential topic. IQNs are faced with the challenge of managing care assistants who are an unregulated and largely untrained group. IQNs often have had no previous experience with directing and delegating care and
responsibility to others - in fact, they are often observed doing clinical work themselves that could have been delegated. A workshop initiative has been commenced in the course whereby a relationship manager from Immigration NZ runs interactive sessions where nurses must ‘manage’ challenging health care assistants. This has proved one of the most popular sessions in the course.

**Practical Learning**
Some nurses preferred practical learning over theoretical presentations. This was reflected in observations made of the difference in classroom engagement as compared to more animated, engaged practical sessions in the lab. Learning styles vary but perhaps Asian nurse education curricula emphasise tasks and performance learning, as suggested by Participant A: “So when all the theory things happened, we can’t remember all those stuffs, but when something practical happens we tend to remember it more rather than theory” (Participant A).

**Wounds and Medications**
Much of the work of the registered nurse working in aged residential care relates to wound and medication management. A large proportion of IQNs begin their New Zealand careers in aged residential care. The significance of these topics was noted:

> And I start to work in an aged care residency I saw that the wound products that I used in that particular aged care, or maybe overall in NZ, the wound products are entirely different that we used back in our own country. So, it was kind of very difficult to understand the different kind of wound products. (Participant A)

Difference between country of origin and the New Zealand clinical context was reflected as participants continued to comment on this sub-theme and suggestions were provided to address this in the course:

> I think if you give more important (sic) of wound products and something like familiarising the students with more commonly used drugs in NZ like... because the products that are used in my country are different and so whenever we come across a drug we have to Google and search it for what is the alternative for what the drug is called in our country. Making a workbook to find out alternative drug names, they can do a research in there. If they are familiar with the alternate names of the drugs from their country, so they won’t have a very hard time when they come here. (Participant A)

**The clinical examination**
Candidates need to successfully pass a clinical examination in the theoretical component of the programme. This comes at the end of the first two weeks and is a peak time of stress.
I have often wondered if the stress of the examination outweighed the value of the examination. However, despite the concern, candidates tended to reflect positively on the ongoing benefit of the practical assessment:

*I particularly remember the OSCE because it was the only time when we were exposed to a Kiwi nurse, because my patient in the bed was a kiwi student so that was the first time we had exposure to a Kiwi nurse. And she was like, yeah, when we were asking her questions, she was replying to us. And that was really helpful and you know, when the CAP programme was finished that was what particularly stayed in my mind ... the OSCE really helped us.* (Participant A)

There is limited opportunity for interaction with “real Kiwis” and candidates valued this first clinical interaction within a safe environment.

**Independent Learning**
Candidates complete 25 hours of student-managed learning ahead of joining the course. While it has been noted that non-Western education systems do not necessarily encourage independent enquiry, nurses saw the value of this different style that was not expected: “If you are taught in the classroom you tend to forget but when you do your own research to find your answers, you never forget it.” (Participant C)

**Kaupapa Māori**
The NCNZ requires that Treaty of Waitangi and its application to nursing practice is covered. This is an area of professional importance, yet it is challenging for migrant nurses as they have such little time to consider the history of colonisation in New Zealand, and the Treaty as a founding document, let alone how it impacts on nursing practice. This challenge was reflected in comments made:

*I think that might be a better idea if they can explain tikaka to the students. It was too brief in my course* (Participant C);

*Treaty of Waitangi was important because it introduced us to the whole NZ culture, but it wasn’t enough.* (Participant D)

**Reflection**
Critical reflection on practice is an integral component of nursing education in New Zealand as well as during nursing practice itself. Candidates are required to complete a critical reflection on a clinical exemplar or professional story during their practicum placement. This is an area where international nurses have struggled greatly. In conversations with me, candidates—particularly those from India—have talked about how new the concept of reflection is to them, and how they have never been
required to reflect on their nursing practice or themselves. Participant J spoke about the focus being on the patient and not themselves as a nurse:

*It’s not the culture - the way we were taught nursing...there’s nothing like a reflection to reflect on what you learned or what your think... even at school, kids don’t write stories about themselves, about how they feel about things... we always concentrated what was in the books and exams....because even in the nursing, you only think about the patient you are caring for, you never think about yourself.*

(Participant J)

**Difference in education systems**

A recurrent theme noted was the difference in how students learn in their home countries compared to their learning experiences at Otago Polytechnic. They often noted how they expected the teacher to provide all the “facts,” teaching and informing the nurses how to nurse in New Zealand. Group activities like small group discussions, the expression of individual opinion, and offering an opinion different to the lecturer, were reported to be new and, sometimes, uncomfortable experiences. Nurse learners were often shocked and somewhat disoriented being in a classroom where the teacher seemed so informal and spent time encouraging the nurses to express their own opinions. Common previous learning experiences included a heavy reliance on textbooks and lectures, where it was assumed the teacher held all the information and power and the students’ role was to absorb the information. Participant C reflected on the differences they noticed in relation to the classroom culture in New Zealand:

*Only one-way lecturing with the teacher just explaining – uses the board. There is no two-way interactions happening there. It was two-way in my CAP programme and was very happy to see that because the students from India they keep lots of respect to the teachers so when they come, they automatically stand up - which I think it is different from here. Lots of difference with all the culture as well. Even in the class I still remember that won’t eat or drink in the classrooms but here I have seen the students can.* (Participant C)

While the differences in classroom culture were new and different, they weren’t always popular:

*I know about the new ways of teaching, but my preference is that with a short period, I’d rather you just tell me – I feel that a lot of time is wasted in group work when you can’t really come up with something.* (Participant E)
However, it was more common for participants to appreciate and enjoy the new ways they were experiencing in the classroom. It would seem they appreciated a more balanced power relationship with the teacher:

_The way we are raised up at home, there is a distance between the teacher and student relationship. We will not call the teacher by their names – only Sir or Madam or Miss. I felt very happy and proud to be here and could just relax and sit in the classroom._ (Participant F)

The difference between Indian and New Zealand classrooms seemed more striking than with comparison to the Philippine system. One Indian participant commented on the absolute power that the teacher has in India, a level of respect that, they observed, was not apparent in New Zealand: “First, you know, there is Mother, then Father, then comes Teacher and then God. This shows you how much we respect our teachers back home.” (Participant H)

It would appear that coming through a CAP course also has secondary learning effects. Nurses, already graduates from tertiary institutions, gain new insights into learning and growing – preparing them for post-graduate study in their new homeland.

**Struggles**

Migration is a stressful process. Those who choose to leave their country of origin leave behind friends and family who have supported and encouraged them. Separation from social networks and support systems is difficult and is a major part of the challenges migrating nurses face.

Most nurses who migrate have never been to New Zealand before and know little about the country before arriving. One of the themes that came out from nurses who had been in New Zealand for several years was the struggles that they faced as they adjusted to their new country, new home and new work colleagues. Areas of struggle that were identified from Group B related to communication, accommodation, transportation, the new healthcare system, the experience with the preceptor during their CAP assessment, end of life care, and patient refusal.

**Understanding the Language**

Unfamiliarity with accents often poses an unanticipated challenge, as while nurses may have felt confident in their ability to communicate in English—they have proven through their IELTS or OET forms of English language testing—the way New Zealanders speak is seen as unique and not related to more familiar accents, such as more media-dominant accents. For nurses who have migrated to English-speaking countries, their previous experience with English has
often been limited to media such as films or YouTube clips. The New Zealand accent is unique and therefore is largely unfamiliar to nurses coming from the Philippines and India, as noted by Participant D: "I struggled with the language at first – I am used to American English so talking to Kiwis, with a Kiwi accent was a struggle."

Not all generational age groups sound the same to the international nurse. The difference in vocabulary along with difficulties in the articulation of the speech of the elderly can add to the challenge for new nurses to New Zealand.

**Being Understood**

In the previous example, the nurse acknowledged that their own accent could prove a challenge in the interactive communication process. Accent is a universal phenomenon. While some international students may not feel they have an accent, IQNs seem to become more aware of the difference in their voices and their ability to speak English after having been in New Zealand for a while, as raised by Participant H:

> We’ve got different dialects and we’ve noticed that some regions are better in speaking English … I think it’s how our tongue works, like some dialects are so hard… it’s so hard to pronounce English words (Participant H).

The struggle to engage in effective communication was not only with being able to understand but also to be understood. Not knowing acceptable words and phrases confounds the ability to fully engage in conversation. Not wanting to appear rude is a valid concern. For many Indian students, it is quite acceptable to conclude an email to a teacher with, ‘so please do the needful.’ This can be interpreted as a directive from a student that is not usually found in communication between lecturer and learner.

The struggle of communication may also impact upon perceived prejudice that international nurses face. For some, they feel judgement due to the differences in the sound of their voices, as Participant R expressed,

> It’s a two-way thing. They always complain about (communication) … it’s a biasness, whether someone has his accent like my accent, is a little bit different to your accent. And some people try not to listen … and some is very interested and yes, listening. So, it’s not a one way … it’s a two-way thing. (Participant R)

However, communication becomes less of a struggle over time. Adjustment in language comprehension, as well as articulation of English within the New Zealand context, occurs as international nurses become immersed and saturated in English as the dominant medium in communication. One nurse believed that it took years to become proficient in
communication: “I think it takes 2.5 years to be able to communicate well with the residents but to be an effective communicator, like it takes 3 to 4 years” (Participant H).

This is something those who assess newly-arrived IQNs in the CAP need to mindful of – international nurses voices and language comprehension is continually changing, and initial assessments of communication should primarily focus on safety, knowing that fluency in language articulation and comprehension will develop.

Accommodation
For most international nurses joining the CAP at Otago Polytechnic, their accommodation arrangements are temporary and uncertain. During the Covid-19 pandemic times, international arrivals needed to spend two weeks in a managed isolation (MIQ) facility. Obtaining a place in a MIQ facility could prove challenging due to the limited number of places. It was a struggle for many to secure a place. They may not be familiar with other forms of accommodation, such as backpackers’ hostels and homestays. One participant found that staying in a backpackers provided much needed social support: “I had a backpackers accommodation for the theory time, so the receptionist gave me a map and told me where to go – we all supported each other in the backpackers” (Participant C).

Some sought further accommodation arrangements once they had arrived in the city. They may start with a homestay, but then will find cheaper options with people from their own culture, as was the case for Participant C: “We do have a Malayalam community in Dunedin and a Facebook page, so if they want any accommodation, they can just leave a message there.”

Nurses can experience difficulties even when placed in supportive accommodation situations, such as with a homestay family. This was so for Participant K:

*Hardship, when I first come. I was not matched properly with the homestay I was with because my homestay was of a different religion to mine. I was struggling to adjust to the family I was with – there were so many limitations.* (Participant K)

Accommodation is more than simply a form of shelter. A home is a social system and nurses have struggled within new social environments that may have been assumed to have offered support. Additionally, seemingly isolative living arrangements, such as a backpackers, can offer opportunities to connect and bond with other people from other regions or countries.

A New Health Care System
The New Zealand health care system is complex and based on Western models of health care. With divisions made up of primary, secondary, and tertiary levels, differences may be seen when compared with other health care systems that are less organised and financially
supported. One distinctive difference that international nurses often comment on is the aged residential care sector in New Zealand – an area of health care that is not prevalent in either India or the Philippines: “This was a struggle as well: the different health care system. The model of being in a residential care facility is very different” (Participant D).

International nurses are not familiar with institution-based continuing care of older people. Extended family networks are often responsible for providing care of the elderly in Asian cultures. In addition, the role of the registered nurse in an aged residential care facility carries more responsibility, due to the high resident-nurse ratio and the prevalence of care assistant staff who need to be directed and delegated to. This difference was raised by Participant K:

We are not really aware as to what are the things and the services that are being provided in an aged care facility ... the role of the nurse, what they can do, who they can refer to... (Participant K)

The Preceptor Experience
This is perhaps one of the most significant aspects of participation in professional assessment. The clinical placement made up of a total of 240 hours of continual scrutiny by the preceptor. To be eligible to take the role of preceptor, a New Zealand registered nurse needs to have held registration for at least three years and have completed a preceptor course. Working with already qualified nurses is quite different to supporting a nursing student, and candidates in the programme often experience being treated as if they were a student. This can be confused when the candidate sees themselves as needing to learn the New Zealand way and may appear to behave as if they were a student.

There was a significant amount of feedback related to the preceptor experience, surprisingly negative. It became apparent that there is a competence in the role of being a peer assessor and that despite the role requirements, there still appear to be difficulties at times. Sub-themes identified from participant responses included: support, expectations, initiative, power, and prejudgement. While many of the respondents reported to have felt supported by their preceptor, others felt unsupported:

My preceptor wasn't very supportive ... these people have been [precepting] for many years now, so they should know how to work with an international nurse. (Participant E)

Clarity of expectations of candidates is important. When working with colleagues from different national backgrounds, assumptions and expectations can be misinterpreted or unspoken. The showing of initiative is a universal expectation when nurses are being assessed as able to perform their role. However, this can be difficult when the candidate does not know what to show or how to show it:
She said, ‘I expect you to have more initiative’ - this was so vague (Participant D)

I don't know what she’s thinking, I don’t know what she’s assessing in me. I don’t know how to show her how competence I am. Being a preceptor, you are a facilitator, you should be able to give a chance to the student to showcase themselves. Give them a chance. (Participant D)

Role confusion can follow from unknown expectations. As mentioned earlier, the qualified nurse can find themselves behaving and being treated as if they were a pre-registered student: “I was battling within myself: what my role is: am I a student or am I a nurse?” (Participant D).

It is important, in a relationship involving peer assessment, that roles and expectations are discussed and clarified. When there is uncertainty, a power imbalance can occur: “I was so powerless. I felt there was nothing I could do” (Participant D).

Participant D went on to talk about the experience of prejudgment. Upon reflection of their precepting experience they said, “It felt like during my first week, I was already prejudged by my preceptor... as a preceptor, you should also think there'll be good days and bad days” (Participant D).

Participant D had a negative experience as a candidate for registration. Their interview was one of the longest and most significant; the candidate was not passed as competent at the conclusion of their placement. This was a powerful experience for me, as it highlighted aspects that I had not considered before, about the competence of the preceptor. See appendices for further discussion on this participant’s experience.

End of Life Care
Palliative care in New Zealand is a reflection on how society views death and expectations of care when cure is no longer possible. Each group of CAP candidates spends a half-day workshop at the community hospice, reviewing how palliative care is delivered in the New Zealand context. In the first part of the workshop, candidates are asked to talk about their previous experiences of caring for dying people, and to share how death is viewed in their culture. It has become evident to those teaching in the workshop, that there can be quite a different philosophical approach to death and the provision of medication to promote comfort when cure is no longer possible. This may equate to a form of moral distress for candidates, as several have commented that they see some aspects of palliative care (e.g., medications) as a form of assisted dying. This is a struggle for many international nurses and has been evident in the post-registration period when employers have noted the reluctance of some IQNs to participate in palliative care regimes:
Dying: it was a dilemma for me on how I approach end of life... I didn't consider the quality of life - I didn't consider that we are just prolonging the suffering. We are here to care for them, to help them transition peacefully comfortably and being pain free.  

(Participant K)

Patient Refusal
Unfortunately, some candidates have experienced prejudice from their patients. While professions can set standards and codes of conduct to ensure collegial respect within teams of diverse backgrounds, the general public can, at times, be less accepting of diversity. While most patients are grateful for the care that any nurse offers, there are occasionally times when they may refuse an international nurse to provide the care they need, as was the case for Participant R: “Sometimes it is a challenge dealing with the person who is a little bit ...you know, somebody don’t like the foreigner is a little bit challenge. But some really don’t like the colour or something.”

International nurses, undergoing assessment will typically not report or complain about patient refusal or racial statements they may hear. One participant talked about an oncology patient who asked, “Can you please just get me a New Zealand nurse... no offence but....?” It turned out that the candidate had far more extensive experience in oncology than their preceptor and so was able to offer care based on more extensive clinical experience. This candidate did not complain and only mentioned this interaction in passing. Many struggles are not spoken of and are seen perhaps as ‘par for the course.’

Talking with patients
Candidates, after having worked in New Zealand for some time, reflected on the value of communication within the course content. Clearly, they faced challenges in communicating with some of their patients.

Candidates often seek to learn specific words and phrases. During the end-of-life workshop, they will ask what to say to families and patients who are experiencing the approach to death. Communication is culturally defined, and this is recognised by the nurses as they recognise that previous ways of speaking back home, might not be suitable for here: “She could have taught us a lot more expressions, armed us with things that we could say” (Participant F).

Collaborating with colleagues can be challenging. This is found when interacting within hierarchical hospital teams. International nurses often feel disempowered within these settings and, during the course, are encouraged to find their ‘CAP voices’. Candidates are encouraged to speak more loudly, more definitively, more confidently during the two-week component to prepare them for the style of interprofessional communication found in the New Zealand clinical setting. Participant F reflected,
Finding your CAP voice: I think that is centring - being able to communicate themselves very well to doctors, to patients, to their colleagues is I think a very important component of the two-weeks. (Participant F)

Adjustment

This is probably one of the greatest challenges for the migrating nurse: transitioning from a lifestyle and work setting that is very different to the New Zealand system. Nurses usually came from hospital-based employment, having worked in settings that were strongly hierarchical, with patriarchal power structures controlling communication and power.

Conversational challenges

The international nurses themselves, acknowledged the long journey that communication competency takes. While many ‘assessors’ of competence in the clinical setting will judge language competence from the first day of placement, this is unrealistic as migrants take months, even years as they continue to grow in language fluency. The clinical placement settings are either in acute care hospital areas or in the aged residential care sector. Communicating with the elderly can be additionally challenging for the migrant nurse:

  Still sometimes when I talk to the old people, they use the old phrases and stuff... I just laugh at them and smile at them. Often, they just wanted someone to listen so they're happy with that. If a new IQN is working with kiwis, it'll take a few months to understand the normal conversation. (Participant J)

While often being comfortable with ‘regular’ English, candidates face the challenges of the nuances and idioms of the host country. For nurses interacting with patients, the casual forms of communication can take time to become familiar with:

  The jargons which was another thing – we just only know how to speak the normal English – we don’t know what the Kiwis use in their speech “box of fluffy duckies” and all those things. (Participant C)
For some, communication could be a hurtful aspect of adjusting to a new culture. Again, a sub-theme of racism was implied:

> They always complain about (communication)... it's a biasness, whether someone has his accent like my accent is a little bit different to the your accent and some people try not to listen. (Participant R);

> I was shocked with the patients. I found people being sarcastic with me. There was a workmate before who called me "oh like you're a cheeky monkey".. I felt so offended by that... you just called me a monkey. (Participant D)

**Culture Shock**

Difference can be felt in a wide variety of dimensions. Traveling to work in another country where patients and colleagues look, sound, and act different can lead to a cultural disorientation. This is particularly felt by Indian nurses, going by the number of Indian participants who mentioned the how different things were for them, as elucidated by Participant A:

> For Indian nurses, especially those who haven't worked in other countries, for them it is very difficult because this the first time when they see somebody who is not like them. You know what I mean. So, the first time they see they are different, they look different, they talk different, their accent is different, they eat and dress different - so everything is difficult, so this is a cultural shock.. (Participant A)

Respondents gave suggestions for how culture shock could be alleviated in the initial phase of the programme:

> I think it would be more efficient if you don’t start the theory as soon as they arrive – just do some practical things or maybe take them outside the classroom, familiarize with people and when they are settled from inside, and when they are more relaxed and blend in with the environment, at that time start the theory classes. (Participant A)

**Social Support**

Missing home, friends and family was a common phenomenon. Many of the migrants had travelled alone and were living in temporary accommodation such as backpackers, homestays, flats, or hostels. Nurses found support from accommodation staff, who helped orient them to the new city. Homestay students reported mixed experiences from their living situation. While some homestay families were warm, welcoming and provided support through taking students around the region, others reported more negative experiences.
These adverse experiences were often not discussed spontaneously but after purposeful enquiry by the lecturer:

*It is so cold – I was not allowed to use the heater for more than one hour. They told me to wrap the electric blanket around me.* (Participant F);

*I was not allowed to cook my own food – they said it smelled bad and made a mess. I didn’t know where to have my food so I sometimes only ate at the Polytech.* (Participant D)

The nurses were a source of support to other as they journey through the course. They had a shared understanding of the migration experience. Food and eating together was identified as an important time for socialisation. Students talked and shared experiences both from their home but also how they were finding the course material. However, students would often sit with members of their own country - they seemed to find it difficult to mix and get to know each other. One nurse suggested the class be mixed up in classroom seating to encourage communication with nurses from different backgrounds. Participants talked about the value of their newly formed friendships in the group; this was something they valued and helped them cope with the stressors of migration and the course.

**Communication**

This is a significant topic within a competence assessment programme. The regulator of nursing practice, the NCNZ, places emphasis on the assessment of a nurses’ ability to communicate safely. Candidates must pass formal English language testing before entering a programme, passing either the IELTS or OET assessments of language. Also, during the practical six-week component, English language proficiency is assessed again, within the clinical setting.

Therapeutic communication is a form of professional communication unique to nursing. It emphasises the use of communication as a nursing tool to benefit the patient. It is based on Western ideals of encouraging the expression and exploration of feelings, focusing completely on the patient (rather than the clinical task), and valuing and validating the patient’s perspective and experience. Some international nurses’ experience has been to prioritise tasks over interpersonal interaction and, therefore, therapeutic engagement maybe something new and unfamiliar compared to their most recent clinical experiences.

Many of the responses from the Group B participants related directly or indirectly to communication. It appeared to be a source of frustration as well as joy. In reflecting back, sometimes years after their initial experiences of coming to New Zealand, the participants were able to evaluate those early interactions with insight, having completed
their migration journeys. By listening to migrant nurses’ voices as they looked back, we have been able to learn from the phenomena they experienced - both positive and negative.

International nurses are often criticised for sounding different. Their perceived accents have been a point of criticism throughout the history of the competence assessment process. However, I was not aware of any commentary on how New Zealanders’ accents might pose a barrier to international nurses – it was evident that for many, the ‘kiwi accent’ was a challenge, as mentioned by one participant: “I struggled with the language at first - I am used to American English so talking with the kiwis with kiwi accent was a struggle” (Participant D).

It would be interesting to survey New Zealand-raised registered nurses to enquire of their awareness of their own accent and the impact this might have had on collaborating with international colleagues.

Another barrier to effective communication in the clinical setting for the international nurses was the accent of the older New Zealand residents in care. Language and its articulation has varied over the generations and communicating with the elderly can be difficult for some. Idioms and generational differences in style of speech pose additional challenges to new nurses to New Zealand, especially in the aged residential care sector. One participant commented on the challenge for the elderly in her clinical placement when she communicated during her CAP clinical placement:

Language, that’s the problem; especially understanding the accents of the very old people there. They weren’t able to understand me sometimes because of my accent. That was one of the challenges I faced. They were all very supportive. Within one to two months I think I made it. (Participant C)

IQNs arriving in New Zealand and commencing the CAP have many things to learn. Amidst the clinically oriented curriculum content, there are other unrecognised learning needs. One participant spoke about this when they said, “With English language, it’s so hard to know how to talk to people without being misunderstood, without being rude or being too direct” (Participant H). Nursing is an interpersonal discipline that relies heavily on accurate and therapeutic communication. The participant above, reflected the need to address differences in communication that new arrivals find.

The style and content of communication varied, and it was not surprising that migrant nurses found these differences a challenge. The duration for adjustment to a new style of communicating can be years. One participant proposed to offer a timeframe for how long he felt it took to adjust to the New Zealand way of communicating: “I think it takes maybe 2.5 years to be able to communicate well with the residents but to be effective communicator, like it would take 3 to 4 years” (Participant H).
Anecdotally, those working with IQNs CAP candidates in the clinical setting have expected a rapid pace of change and adjustment in communication abilities within the six-week clinical placement period. Given that communication adjustment is a process that extends over years, assessors (preceptors) need to be reminded of this reality.

IQNs noted differences in English-speaking competence even amongst themselves as a CAP cohort. While some candidates have appeared animated and confident in their articulation of English, others have remained quiet and seemingly reluctant to participate in classroom discussions. Participant H gave some explanation as to why language fluency, in the early stages of the CAP Programme, may vary amongst the group:

We’ve got different dialects and we’ve noticed that some regions are better in speaking English... I think it's how our tongue works, like some dialects are so hard... it's so hard to pronounce English words. (Participant H)

There is an assumption that all nurses from a particular country have the same level of experience and opportunity to speak English. In India, most nurses, although educated in an English medium, will work as registered nurses using their indigenous languages only: Malayalam, Hindi or Punjabi. Nurses from the Philippines may have more experience in English as it has been more widely spoken in the metro areas. However, those nurses coming from provincial Philippine regions will have had much less experience in English and will largely have communicated in their regional dialect. I was interested why some of the candidates, when in class, hardly spoke at all during the first two weeks. I posed this question to a group of enrolled candidates who reflected that some may be reluctant to speak due to fear of judgement from others from their country. Language, and the ability to speak English language, can be seen as indicative of a family’s socio-economic standing in their community. This may help explain intracultural and interpersonal forces within the international classroom situation that has impacted on communication within the classroom and clinical settings.

One participant spoke about encouraging students in the classroom:

... especially for Indian nurses from what I have seen, is that they are more feared and scared compared to others and they have a lot of thoughts in their mind but they won't express themselves and I think that they if you give them an opportunity, if you ease the atmosphere and give them a chance to speak up then definitely they can express themselves a lot. So they just need a medium, warm friendly environment. (Participant A)

I devised the notion of developing the “CAP voice” – this is a repeated encouragement I have made to classes, to develop a new way of speaking. This CAP voice is one that is characterised
by assertiveness, clarity in enunciation and pronunciation. This acknowledged the difference between previous ways of speaking back home and expected styles of communication in the New Zealand clinical context. The hope is, that candidates will feel more confident and ready to communicate when faced with the challenge of being immersed in a wholly New Zealand verbal environment. Sadly, this was not always the case: When confronted with six white professionals in front of me, I find myself cowering in fear and losing that voice - CAP voice... (Participant F)

Again, participants have commented on the challenge they faced in the clinical setting when working with native NZ English speakers. Participant D felt that the lack of communication from his NZ preceptor had a detrimental impact on his ability to succeed during his clinical placement: “The preceptor doesn’t talk to me, like what she wants me to perform, what she wants me to showcase. I'm happy to do that if I'm communicated with” (Participant D).

While criticism around communication competence has largely been directed towards migrant nurses, it was apparent that the ‘local’ nurses could also have issues around their own communication competence. A reluctance to offer timely feedback to international CAP candidates during their clinical placement has been seen among some New Zealand trained RN preceptors. It takes courage and skills in assertiveness to be able to address deficits in clinical practice and for some preceptors, these may be skills they are yet to develop.

Clearly, communication is a powerful component of a migrant nurse’s journey. Familiarity with communication styles and expectations within new clinical cultures can empower a nurse to understand their early experiences. Communication is a therapeutic tool in the nurse’s skill set. It is essential as a way of forming therapeutic relationships with health care consumers. However, it can also be a barrier to a nurse undergoing professional assessment in another country and the impact that communication has on the authenticity of assessment needs to be appreciated by those responsible for assessing.

Quietness
There are numerous dimensions to a migrating nurse’s journey which shapes their sense of freedom to be themselves and be able to demonstrate their professional competence. International nurses are often criticised for their communication behaviours in the clinical setting. Communication is a socialised phenomenon that is shaped by cultural norms and mores. Quietness and power are essentially linked themes. Quietness was something seen and acknowledged by the nurses in the enquiry as in this example where the nurse explained why nurses may seem quiet in class: “Some of them are very scared ... and if they have any doubts they won’t ask others, like they just keep in it their mind” (Participant H).

International nurses may also feel a sense of embarrassment around spoken English. It is often noted in classes, that silent students might be reluctant to participate in discussion, yet
academic assessments may show high levels of understanding: “Filipinos can be shy to speak up because we are very conscious with our grammar... we don't want to be embarrassed, to get embarrassed because we said the wrong grammar” (Participant G).

One participant spoke about a crab mentality in communication whereby there is a reluctance to appear above others for fear being pulled down:

...this is about pushing one down because someone's trying to become successful, I was like that during my CAP, I knew the answer but I didn't want to talk (Participant K).

Fear
Fear was a sub-theme from the interviews. The previous participant spoke about fear within the learner group while others spoke a fear of failure:

They are spending so much here and they don’t want to open their mouth and maybe, they’re thinking if something goes wrong, they can’t continue with that – they’ll be in deep trouble. So maybe they’re just keeping quiet and taking it so, it all impacts. (Participant B)

It is generally accepted, that the person in the role of assessor and decider, will be in a position of power. The decisions made during the time of assessment determine outcomes and futures for migrating nurses. The experienced international nurse group spoke about their perceptions of the power differential while undergoing professional assessment. As mentioned earlier, one Indian nurse referred to a hierarchy of respect she felt existed in her culture: first there is Mother, then Father, then Teacher, then God. I became aware of the level of respect that students in India and the Philippines attribute to teachers as well as to those senior to them in the clinical workplace. This, then, is the power of socialisation that the nurse brings with them. This can be seen in the classroom where IQN students are seen to prefer to remain silent and even prefer, as evidenced from Group A responses, lectures and demonstrations rather than group discussions.

Clearly, there are several powerful forces that impact upon a nurses’ verbal interaction. Through understanding cultural differences in the socialisation of nurses, teachers, assessors, and colleagues can encourage, support and empower international colleagues to become their new international self and participate effectively in their professional collaboration.
Beginning employment post-registration

The completion of the eight-week competence assessment programme is a high-point in the migrant nurses’ journey but does not mark the end of the challenges they face. International graduates quickly enter employment – the current workforce crisis has provided them with significantly more options for employment. Previously, they often found difficulty in gaining hospital-based positions and made up a large proportion of the aged residential care staff. Transitioning to a new role and workplace is the next challenge a migrant nurse faces.

However, this is a short-lived issue as the nurse adjusts to the accents and generational differences in communication. Most of the nurses in Group B had started their nursing careers in New Zealand working in the aged residential care sector – an area of nursing they were previously unfamiliar with. The direction and delegation of care givers or health care assistants posed challenges that they recalled years later, as was the case for Participant J:

> You have the caregivers... it can be really... all their years of experience, they can be very... I don’t want to say, “bully type” but bossy type person where you have to control them because you are the RN and you need to make sure you have a voice. So I’m a bossy person, I have my voice. But it took me a while to feel that they do agree that I’m their boss or a registered nurse and that I do know something. (Participant J)

Nurses spoke of how, back home, it was undesirable to challenge an older person who perhaps could be seen as an aunt or parent. The age difference between IQN and caregivers might impact integrational communication and the ability for the international nurse to deal with ‘challenging communication and behaviour’ as suggested below:

> Back in the Philippines, most of our colleagues are the same age... and we also have that hierarchy ... but when [I] came to New Zealand, there’s not hierarchy at all... like everyone is treated the same. So that’s why it’s so hard to manage staff who are older than you. (Participant I)
Nurses talked about the challenges that newly appointed IQNs face in the clinical setting:

You have to prove yourself to co-workers... there is already a stigma in you - that you’re not good enough ... once you can speak out they don’t touch you anymore. ... you have to prove up something... it’s either just speaking out or you are good at something (Participant E);

When confronted with six white professionals in front of me, I find myself cowering in fear and losing that voice [CAP voice]. (Participant F)

Employers and managers were noted to be important in the transitioning period: “She told me about those who wouldn’t listen and she said, don’t worry about that one – you just come and talk to me. That was good support from the manager” (Participant E). This nurse spoke about the positive influence her supportive manager had upon her ability to adjust to the staff, residents and expectations in her new role as a registered nurse in aged residential care. Registered nurses often work alone or with only one other registered staff member on shift. This places larger amounts of responsibility upon the newly employed registered nurse compared with those commencing in the hospital setting. Acute care areas provide continual medical and nursing support – again, highlighting the importance of supportive managers and transitional support programmes.

Therefore, what these nurses’ responses showed, was the importance of respect in their own social hierarchies. The migrating nurse, once comfortable operating within the norms of traditional workplaces, must navigate different social systems and expectations around interpersonal relating in the New Zealand workplace.
Discussion

In this section, I compare and contrast the findings from the two groups, and also illustrate how my findings compare to Maslow’s hierarchy specifically, and other previous literature. I also offer suggestions and recommendations for improving teaching and providing more support to meet the needs of international nurses. Some of these I have already put in place in my own teaching practice, and others are those I will take forward into the new working groups with NCNZ and Te Pūkenga. The working groups will be looking at a new system of assessment and transition for internationally qualified nurses from 2024 onwards.

The case study research method allowed for the examination of the lived experience of the migrant nurse. Triangulation of information was achieved by drawing from the experiences of newly arrived migrant nurses, those who had been here for some time and professional (work-based) experience of myself as a tertiary educator.

Groups A and B represented international nurses who were bringing new and experienced perspectives, respectively, on migrant nurses joining the New Zealand profession. They brought a sense of hope, anticipation, and wisdom to the enquiry. Their responses provided an understanding of how Philippine and Indian nurses saw their migration destination and why they chose to sacrifice much in their lives, to come to New Zealand. In the first part of this discussion, I will look at what I have learned about the reasons for migration and follow on to examine key components that the nurses identified they needed from a CAP course.

The motivation to have left one’s life and work behind was a powerful force. Maslow’s hierarchy of human needs provided a framework from which to better understand this motivation. I intend to outline a new model of migrant needs, based on the Maslow structure, to provide a theoretical representation to use in future presentations and research related to advocating for international nurses.

Additionally, the need for safety was another reason nurses had chosen to come to New Zealand – they believed that they were moving to a place where their family would be safer. Nurses referred to the pervasiveness of corruption throughout their society, along with high crime rates, as they reflected on how much safer they believed New Zealand to be. They spoke of violence that had occurred within the hospital setting and the daily risks they had faced with little regulatory or occupational protection. This directly related to the hierarchy: level two of Maslow’s physiological needs acknowledges that people seek to feel personally safe. This related to my experience of addressing personal safety with nurses travelling to and from health care facilities to attend shiftwork based placements. They seemed unconcerned about walking long distances through the central city at night time. Nurses from New Delhi, for instance, spoke of the constant, daily harassment they faced when travelling by congested trains to and from hospitals. They also spoke of the physical harassment they faced from
patients and their families. The need for safety and esteem were powerful motivators for migration.

**Respect**

I felt I gained a greater understanding of these nurses’ perceptions of themselves. One theme that resonated with me was respect. It was clear that a number of nurses had chosen New Zealand as their migration target due to the greater level of professional respect, they believed they would experience here. Several commented on how little respect they received as nurses in their home country. The Indian nurses in the study related how lowly the nursing profession is ranked in a traditional hierarchically structured society. This was not necessarily the case in the Philippines, where nurses are commonly regarded as ‘overseas working heroes.’ Filipino nurses contribute a significant amount to the gross domestic product back home through international remittance. Similarly, Indian nurses also send a significant proportion of their New Zealand earnings back home to support family and community. I was able to connect the concept of respect with the fourth level of Maslow’s hierarchy that related to esteem needs. It was evident that nurses were migrating, seeking to find professional respect and recognition as health care professionals.

In New Zealand, the nurses hoped to find respect and recognition for their education and experience. They wanted to develop their careers and participate in educational opportunities that would enhance their professional development. Alongside this, they also expressed a sense of adventure. They had heard that New Zealand was a beautiful country and that it was a good place to raise a family. The nurses saw educational opportunities, not just for themselves through the CAP process, but also for the children they had or hoped to raise in their new country. Family life was important. A better health and education system was a common reason for their choice of New Zealand.

The nurse participants from Group B did not make reference to a lack of respect or recognition that had experienced since registering and working in New Zealand. This was interesting as other studies have shown a lack of collegial respect and recognition for skills and knowledge to have been something experienced in the post-registration period (Primeau, Champagne & Lavoie-Tremblay, 2014).

**Scope of practice**

While other studies have found that migrating nurses have reported limitation in their scope of practice compared to previous skills performed (Clubb, 2022), the nurses from the present enquiry did not agree. They were aware that the registered nurse’s scope of practice was more broad in New Zealand. This was corroborated by the registered nurses in Group B who concurred that many of the skills and responsibilities performed by nurses in New Zealand, were in doctors’ scope of practice in their home country. For instance, assessing and deciding on wound management; having end of life conversations with patients and families; and,
medication reconciliation, tended to be performed by doctors both in India and the Philippines. Nurses from Group B who worked in aged residential care, spoke about the importance of being able to manage wounds effectively and having a thorough knowledge of wound care products and medications.

This has been acknowledged and changes have been made to content around these areas. A wound care specialist now runs a workshop in the CAP, looking specifically at assessment and management of complex wounds. Learners get to examine contemporary wound products and become familiar with indications for their use. This change has proved hugely popular with positive feedback from the aged residential care sector managers, commenting on CAP graduates’ knowledge around tissue viability and management.

Additionally, medication knowledge was identified as a critical area from the experienced nurses – acknowledging that while migrant nurses may be clinically current, their knowledge of New Zealand pharmaceutical schedules may be lacking. Again, course content has been changed to give a greater focus to this area, requiring more self-directed study around medication safety.

Another difference found was the importance placed on patients’ rights in New Zealand. The participants valued the level of moral standards of care and, again, this had attracted them to the New Zealand workplace. The nurses acknowledged the importance that was placed on culturally safe care and could see the difference in values that New Zealand placed particularly on indigenous rights and care.

In response to these findings, new courses in human rights, the Code of Health consumers’ rights and ethical decision-making have been added to the curriculum. This has acknowledged the difference in regulatory and professional ethics that the nurses referenced in their responses.

**Perspectives on Education**

The enquiry also sought to understand the migrant nurses’ perspective on education and what they felt they needed from a CAP course. My intuition around the type of teaching methods expected of international nurses were confirmed from the survey of Group A. Clearly, they were familiar with more traditional ways of teaching and learning. Didactic, demonstrational, and proscribed forms of knowledge transmission were preferred.

Individual enquiry and reflective learning were a new experience for many. This did not surprise me, as it compared with my classroom observations where learners remained quiet and appeared to prefer to listen rather than contribute to classroom discussions. I had noticed how quiet some of the nurses were with an obvious reluctance to engage in class discussions. Through after-class conversations I had with learners, I realised that the New Zealand
interactional, facilitative approach to learning was somewhat at odds with the educational pedagogy that they had experienced in their undergraduate education back home. The learners said that they had been strongly discouraged from speaking out in class during their nursing education. One learner commented that to speak up and voice one’s own opinion as an undergraduate student were grounds for being asked to leave the classroom. This was something that had been noted in a previous comparison of tertiary education between India and New Zealand, and highlighted why Indian nurse learners’ classroom behaviour was different when observed in the New Zealand classroom (Kukatlapalli, 2016).

It is therefore important that education courses for migrant university graduates, such as CAPs, recognise the difference in pedagogical experiences and, especially in courses of short duration, incorporate familiar ways of learning. Otherwise, there is a danger of educationally excluding learners who are not able to grasp contemporary, Western approaches. For example, reflection is a large component of learning in among the health care professions. Nurses from the present study reported the difficulty and stress they experienced with having to articulate their reflection in an academic assignment during the CAP. Therefore, as a way of increasing familiarity and comfort with reflection, the nurses now complete a short reflection each day on their thoughts and feelings in order to progressively develop the ability to consider and learn from self.

It was interesting that role playing was the least desirable classroom activity. While learners preferred demonstrative lessons, they felt uncomfortable being a part of the social interaction. This apparent reticence to be active in the classroom has not stopped them from taking another initiative that has been brought into the CAP based on the findings above. From a collaboration with a colleague who worked with Immigration New Zealand, an interactional workshop was created to address the differences in workplace culture, often found by migrant nurses. This workshop has proven to be one of the most popular aspects of the CAP course and has been replicated by other providers. Learners explore the roles and responsibilities of nurses in the New Zealand workplace, focusing on assertive communication, advocacy and interprofessional collaboration. Direction and delegation are also explored, along with the challenges that nurses face when subordinates push back and refuse to receive work assignments. Through a combination of demonstration and role play, the nurses experience new ways of communicating and how to overcome historical professional barriers to effectiveness in nursing care.

The nurses were asked what they believed needed to be in a CAP course. Many of the areas identified were to be found in the current curriculum. I had assumed that the preferred content would primarily be around nursing skills and physical duties of nurses, so I was surprised when they indicated that they sought knowledge around cultural and legal differences, as well as expected roles and responsibilities in nursing in New Zealand. I felt comfortable with the outcome of the survey of Group A participants. The information was
specific, relevant and appropriate. They felt that fundamental nursing skills, such as clinical measurements and assessment, needed to be reviewed. This did not match with other enquiries where migrant nurses have reported to feel skill review was unnecessary for experienced nurses (Clubb, 2022). However, from my experience in clinical skills lab classes, familiar areas of nursing practice, such as clinical measurements, can provide reassurance and encouragement, when so much of the other course content is new and unfamiliar.

Nurses also spoke about the need for review of New Zealand-specific topics. The regulation of health care (including nursing practice), quality assurance, health consumers’ rights, ethics, cultural safety, and the Treaty of Waitangi were identified as essential areas. These are areas that feature strongly in the current CAP and are regularly reviewed for currency. This was a reassuring finding. However, gaps in the current curriculum were identified from content areas desired by the new nurses. The New Zealand health care system is a multifaceted and changing entity. While it has been included, nurses wanted to have a deeper understanding of the health system. The recent change from the district health board model to a centralised health administration—Te Whatu Ora—along with Te Aka Whai Ora, provides a timely opportunity to explore the new systems with nurses newly enrolling in the programme. Therefore, a revised and updated workshop on the New Zealand health care system will be added as part of the content revision. This will provide an opportunity for nurses from overseas health care systems to compare and contrast the structure and philosophy, looking at the roles that nurses play to represent differences in roles and responsibilities.

Critical thinking has been an area of concern around international nurses’ practice within a New Zealand context. As previously mentioned, nurses have reflected on the different professional roles of medical and nursing staff ‘back home’ compared to expectations around related scopes of practice in New Zealand. The enquiry found that nurses’ understandings of what critical thinking represented varied greatly. There was an overall accurate understanding of the contemporary notion of this form of reasoning; however, the practice of metacognition, thinking about how we think, was very unfamiliar. Along with the difference in role expectations, the present study has highlighted the importance of incorporating this in a CAP course, both theoretically and practically. The experienced nurses from Group B also mentioned the importance of this cognitive ability and the challenge that this would pose for many nurses coming from their home countries.

**Communication**

Jenkins and Huntingdon, (2016) identified communication as being a significant issue of the migrant nurse journey. This was strongly supported by the findings from both groups of participants. Understanding New Zealand English and being understood were often mentioned with a large proportion of participant responses relating to this area. Cummins (2009) identified assertiveness and delegation as areas of concern for international nurses working in the operating theatre environment. The challenge of communicating with peers,
as well as the directing of health care assistant staff was also acknowledged from Group B participants.

Findings from the present enquiry supported those identified from an earlier major review of literature around Asian migrant nurse experiences, (Xu, 2012). The fear and anxiety around communication in the Western clinical setting was reflected in the present participants’ recollections. Xu, (2012) wrote about the marginalising, discriminatory impact that language differences (including accent) can have, and how this contributes to the apparent quietness found amongst Asian nurses.

**Otherness**

It is inevitable that a migrant person will be aware of the disparity in communication, interpersonal behaviour and values between themselves and those they are living amongst. Several authors have termed this to be the experience of ‘otherness’, (Allan, Cowie & Smith, 2009; Viken, Solum & Lyberg, 2018). The participants in the present study also noted the impact this experience had upon them: the difference felt between self and colleagues. Perhaps when human needs remain in deficit, such as a lack of respect or professional esteem, this sense of unintegration is exacerbated and enduring.

In the second part of this discussion, I will present the Model of Migrant Nurse Needs and provide recommendations for those who support internationally qualified nurses. The aim of my work-based enquiry was to better understand the needs of the migrating nurse. I had chosen the Maslow model of human needs as a framework, as it was one I had used successfully in working with nurse preceptors, seeking to raise their awareness of the human needs of the international nurses they assess and work with.
The Prism Model of Migrant Nurse Needs

The Maslow model identified three levels of needs that motivate a person and, once one the needs at one level are satisfied, the person can begin to address their higher needs. I chose to adapt this model and create the Prism Model of Migrant Nurse Needs that would represent my learnings derived from the international nurses themselves. The adapted model retains the needs categories but provides indicators, which relate to migrating nurses.

Figure 14
The Prism Model of Migrant Nurse Needs (author’s adoption of Maslow’s Hierarchy of Needs, 1954)

- Acknowledgement of previous clinical experience
- Recognition of nursing education
- RN Candidate rather than student
- Freedom to make mistakes
- Need to succeed

THE MIGRATING NURSE

COMPETENT NURSING CARE

CULTURAL INTEGRATION

Esteem
- Freedom from exploitation
- Safe accommodation
- Access to health care
- Employment opportunities
- Environmental safety

Love and Belonging
- Affordable accommodation
- Familiar food supply
- Safe drinking water
- Appropriate clothing
- Social connections at work
- Contact with family
- Family reunification
- Connections with own culture

Physiological needs

Migrant nurses often face temporary, expensive, unpredictable housing options with inadequate heating and shared with unknown people. They may feel unsure of the safety of drinking water and elect for expensive bottled water unnecessarily. They may not be able to find the food that they are familiar with. Their clothing may not provide adequate warmth if they have come from a tropical climate.
**Safety needs**
Unfamiliarity with the city and difficulties with transportation can place the migrant nurse at risk both at their home and travelling to place of study and work. They have no paid employment, little resources to draw upon (often only owning one suitcase of personal items), are unsure of the health services available or how to access them. There is no guarantee of employment and they face financial uncertainty.

**Love and belonging**
Migrant nurses often have no friends, family or contacts and lack friendship and intimacy. Loneliness, alienation and isolation are common experiences. They have often left children, spouses, and extended families behind to build a new life in a new country. Anxiety around childcare arrangements and the threat of infection during the pandemic compounds these feelings of separation.

**Esteem**
Migrant nurses are often treated as students and not asked about their previous clinical experience or education. Rather than being regarded as a professional peer, they are at risk of low self-esteem and subordination to others. Low self-esteem can lead to feelings of powerlessness and worthlessness.
**Recommendations**

Drawing upon the learnings from the participants in the present enquiry, the following set of recommendations have been identified. A number of the recommendations have been implemented already, acknowledging their value in making immediate improvement in the candidate experience in the CAP at Otago Polytechnic, Te Pūkenga.

- Strengthen sessions on the New Zealand health care system, the aged residential care system, critical thinking, wound management, and medications.
- Continue with ‘traditional’ modes of teaching but include more small group work (as opposed to larger group discussion).
- Increase content on New Zealand-specific ways of communication (slang, jargon used in the health care context).
- Provide workshops on de-escalation techniques and conflict management.
- Add content related to staff management (direction and delegation) and supporting New Zealand nursing students.
- Add information on contemporary Māori and Pasifika cultures (as opposed to focusing on historical aspects).
- Remove content on dental hygiene and smoking cessation as this was not seen to be relevant.
- Introduce the Prism Model of Migrant Nurse Needs at the Preceptor Training Course (Te Whatu Ora) to raise awareness of the unique needs that internationally qualified nurses have while undergoing professional assessment.
- Provide more holistic support to the migrant nurse, acknowledging their physical needs as new arrivals to New Zealand, and recognise the psycho-social struggles they experience, including loss from the separation from friends and family.
- Raise the status of the international nurse, reducing the attribution of ‘otherness’ and providing recognition and respect for their educational backgrounds and clinical experience.
- Develop a bespoke International Nurse Entry to Practice programme to support newly registered nurses in New Zealand.
Where To From Here…?

In September 2022, the NCNZ announced proposed changes to the assessment process for international nurses. Previously, the CAP process had been the dominant mode of assessing international candidates for registration. Following a process of consultation and consideration of overseas nurse regulators, the NCNZ has proposed major changes. The current competence assessment system (CAP) will be discontinued in 2024. This will allow time for the Council to consult, devise and launch an alternative system which will consist of an online knowledge examination and an OSCE (Objective Structured Clinical Examination). Formal English language testing (OET or IELTS) will continue.

Te Pūkenga CAP providers have formed a national network and are working as an expert reference group with NCNZ as it formulates the new system. As an active member of this group, I will be sharing my findings with the Council and advocating to ensure that the needs of IQNs, as discovered through the present enquiry, are addressed in new systems. I will be suggesting that Te Pūkenga position itself as a provider of mandatory education that international nurses will need to complete. The Prism Model of Migrant Nurse Needs will be offered as a framework for the consideration of new ways of supporting international nurses to succeed in the new health care system, Te Whatu Ora, and aged residential care.

The discontinuation of the CAP has been lamented by both providers and previous candidates. One of the strengths of the classroom-based system has been the ability to work with the psycho-social needs of the candidates. For example, recently an international candidate was identified as not coping; through providing wrap-around support and counselling, the nurse was able to demonstrate competence and go on to gain full employment. She reported that if it had not been for the support she had received, aside from the academic tuition, she would not have lasted on her journey to working in New Zealand.

I am currently working on a temporary secondment with Te Whatu Ora Southern to support the international nurse workforce. It has been recognised by leaders in the Southern hospitals and the aged residential care sector, that this role has made a significant contribution to assisting international nurses to registration (nurses who would previously have not been eligible for registration). I see this role as becoming permanent and an opportunity for collaboration between Te Pūkenga Otago Polytechnic and Te Whatu Ora Southern in strengthening and sustaining the nurse workforce across the Southern region. Through my journey in the Master of Professional Practice programme, I have developed significantly, both as a tertiary educator and nurse consultant. The outcome of this project has been the recognition of the unique needs of migrant nurses and new roles in supporting and developing the international component of the Southern nurse workforce.
I presented my findings to the Te Whatu Ora Preceptor Training Course and received significantly positive feedback from the group of nurse attendees. The NZ-trained nurses commented how unaware they’d been of the position, challenges and needs of their international colleagues. IQNs attending thanked me for telling their story, verifying the accuracy and importance of the findings. The course coordinator asked if I would continue to present to the registered nurses at the Course, on the needs of international nurses, even after CAP has ended.

I will be presenting my findings in May 2023 to the College of Gerontology Nurses conference, speaking about the needs of internationally qualified nurses beginning work in the aged residential care sector in New Zealand.
Reflective Summary

In this chapter, I will reflect on my journey across the Master of Professional Practice (MPP). I will begin by looking at my earlier self, reflecting upon the work I did on the Review of Learning in Course 1 (see Appendix A). Next, I will discuss my research journey, looking at my fears, challenges, rewards, and learnings. In the third part of this chapter, I will explore my new self; looking at my framework of practice and the three roles I have moved into through this process: educator, researcher and, consultant. I will revisit my original learning outcomes as determined in the Learning Agreement from Course 2 (see Appendix B) and discuss the realisation of these goals. Finally, I will look at future directions and opportunities that may come about as a result of this professional journey.

Beginning the Journey – Understanding Myself Before the Project

I completed a Master of Nursing (MN) in Advanced Practice some time ago. I had been invited to join the Master of Professional Practice Programme as a way of fulfilling the tertiary teaching qualification requirement at Otago Polytechnic. I was immediately interested in this research, as this was an area that was less evident in my professional practice. The MPP provided an opportunity to learn, conduct and reflect upon research in practice. My MN was a degree by coursework, so I had not had the opportunity to conduct an entire research project independently. While I had also completed a level 5 certificate in adult teaching previously, I was eager to update my professional practice at a higher level. The review of learning in Course 1 was an opportunity to reflect on my professional and personal self.

This reflective journey was supported by my course facilitator who guided me in my retrospection. I was surprised at how these weekly meetings became so illuminating as I considered my early learning experiences and how these had shaped who I had become. The meetings took me back to my own initial experiences as a learner, exploring my earliest memories of learning piano as a 7-year-old. My facilitator helped me to become mindful of my pre-professional self, exploring how I learned and how I felt about the different experiences I had with teachers I had worked with. Music played a big part of my early educational experiences, and I was able to consider how different teaching styles and approaches made me feel and impacted upon my own teaching style.

My relationship with the facilitator became rich and trusting. Together we explored my professional journey into international nursing and the inspiring influences that salient nurse educators had. I learned that nurse educators can have varying degrees of competence in terms of their ability to work with nurses from different cultural and educational backgrounds. I became aware of how other people shaped my work-based learning experiences as an early nurse educator, working in a hospital-based nurse education department.
When I looked back at my Review of Learning from Course 1, I recognised that many of my own experiences as a migrant nurse related with those reported in my research. I realised that empathy was an important part of my professional self – a motivating force that was to shape my future interest in supporting international nurses. The opportunity to embark on the MPP journey provided opportunities for me to explore and appreciate the stages of my professional life that informed, influenced, and motivated my career pathway, therefore, allowing me to better understand who I am today as a nurse educator.

Before entering nursing, I had completed an undergraduate degree in psychology. I was inspired by the work of theorists such as Carl Rogers and Abraham Maslow. In fact, the hierarchy of needs is a framework that remains influential, impacting upon my work with international learners and features here in my MPP. I was influenced by the work of Patricia Benner whose *Novice to Expert* continuum of professional development amongst nurses led me to regard myself as an ‘expert’ in my professional practice. However, from my subsequent learning and growth during this MPP, I realised that I was probably more at the preceding level of ‘proficient.’ This was because of my naivety around research and the further understanding of my professional self that was yet to occur. As noted, while I had already completed an MN in Advanced Practice, this ‘clinical masters’ did not adequately prepare me for a role of nurse researcher. Additionally, this previous degree consisted of separate course units that required smaller portions of writing that, while still adding up to 20,000 words overall, did not provide the opportunity for a substantial dissertation.

My inexperience with conducting and writing up a major research project had been largely due to what I now realise was a fear of writing. The idea of writing more than 1,500 words was incredibly daunting and something that I battled with throughout the three courses of the MPP (particularly, Course 3). I would regularly become overwhelmed with the perceived magnitude of writing required, which led me to ‘stall’ on several occasions. Thanks to the support of my facilitator and academic mentor, I was able to regroup and continue. This has made me more aware of how challenging it can be for learners who are faced with large amounts of academic work.

One group of learners who I have a new empathy and understanding for are New Zealand trained nurses returning to practice after having had many years away from formal academic learning. This is one group who I have noticed particularly struggle in the competence assessment process. While my research focus was on the needs of the international nurse, my professional learning has extended to New Zealand nurses as well. Again, empathy was a wise and helpful teacher. I have observed, while working with ‘mature learners’—typically New Zealand nurses who have been out of practice for many years—that they find the amount of work in the CAP overwhelming. They may have been away from clinical practice for many years and the time since they last engaged in academic study even further in the past. I now meet with all nurses who have been away from practice and study before they
commence the programme. I go over the academic requirements, breaking them down into smaller units of work, so as not to overwhelm the nurse with the amount of work they will do. I have also introduced pre-course work, whereby the learner can review the work ahead of time and start to plan out their study schedule. Once they have commenced, I now spend time helping each learner develop their individual study schedule, breaking down each academic requirement and creating timelines. Several mature learners have commented how this coaching has helped them overcome their fear of returning to academic learning, leading often to a renewed sense of enjoyment in formal learning.

I have learned to acknowledge that older students may need more support as they approach academic study and recognise the impact that feelings of being overwhelmed can have. I recently worked with a nurse who had been away from practice for more than 35 years. We created an individualised plan of study, acknowledging the extra support she would need in reading, reviewing, and writing. I coordinated support from our subject librarian and the learning support advisor. Despite much self-doubt and study-related anxiety, she was able to return to nursing and is now a valued member of the nursing workforce.

The Journey of a Novice Nurse Researcher

I recall having feelings of excitement and trepidation while planning the research project as part of Course 2. I knew that my area of interest was international nurses. This group was familiar with me, and, as the project was to be a worked-based learning endeavour, it seemed appropriate to explore the learners who join the Competence Assessment Programme for which I was responsible as programme leader. I have worked with the NCNZ as a contractor in international nurse registration intermittently since 2010. However, I had not considered the needs of these nurses or what their experience was as new entrants to the New Zealand health care system. The NCNZ, as the regulator of safe nursing practice, prescribed the competence assessment process, but from my discussions with other CAP providers around New Zealand, I realised that providers were approaching candidates in different ways.

I saw an opportunity to shape the CAP at Otago Polytechnic to better meet the needs of international nurses. It was this intention that led me to understand the emancipatory aspect of research, whereby participation in research can empower and give ‘freedom’ to an otherwise dominated group. To me, it felt like international nurses were somewhat dominated by the NCNZ and that this was an opportunity for them to become a part of understanding their needs. I felt that I had a good understanding of international nurses and shared this knowledge with other nurses through the Preceptor Course at the then, Southern District Health Board (SDHB) (now, Te Whatu Ora Southern).

I have been teaching nurses, training to be preceptors at SDHB for the past five years. Originally, my presentation was about the process of entering a CAP and gaining registration,
focusing on the roles and responsibilities of the nurse preceptor. However, since embarking on the MPP journey, I noticed that I was starting to spend more time during my presentation talking about migrant nurses, human needs, and how through understanding international nurses’ needs, preceptors can better support and assess them. In fact, the core of my presentation is the Maslow classical hierarchy, and I continue to receive very positive feedback from nurses both formally and informally (particularly international nurses) about how insightful and moving my presentation is. This feedback has been evident in course-evaluation feedback, but also from conversations with IQNs after each presentation. I took the title for my MPP practitioner thesis from a comment that I have heard more than once from preceptors after my session: ‘Thank you for telling our story.’

Two data collection methods were used to explore the IQNs’ expectations and experiences. I chose to survey the first group and planned to conduct semi-structured interviews with groups B and C (where Group C was an employer group). I had underestimated the amount of time involved in devising and conducting the data collection plans and, after consultation with my advisors, I decided to focus the present research project on Groups A and B, since these groups were made up of the population of interest (international nurses). Additionally, widespread Covid-19 outbreaks and dealing with acute staffing shortages made the employer group less available and accessible for research. Nurse managers are commonly needing to cover staffing deficits, providing direct clinical care themselves. I have not lost sight of the third group, those who employ international nurses, but I will examine this aspect of the phenomenon in a subsequent research project. This will now be particularly relevant given the changing landscape of international nurse assessment and the changes to international nurse assessment that have been proposed.

I had a number of concerns about choosing the first group including: their vulnerability as new-arrivals to the country; their potential concerns about how participation may impact upon their professional assessment; the readiness of the new arrivals to participate in an online survey; and the impact that my position as programme leader might have upon the authenticity of the data. I addressed the first concern by providing an explanation in simple language of the purpose and methodology of the study, emphasising the benefits that it could have for future nurses enrolling in the CAP. I utilised an independent collaborator who was responsible for explaining the survey to the group and answering any questions. This person was external to the CAP and was able to reassure the nurses that their responses would not impact the outcome of their course. She explained how to use the online survey and emphasised that the data would not be accessible by me until their course had finished. I was surprised at the high return rate that I got from the nurses and at the consistency in their responses. I had assumed that participation in a research project would not be a high priority for the nurses.
The first week of the CAP is inherently stressful and I believed that engaging in separate project would not prove popular. I had also assumed that the survey responses would have been more variable, and I was inspired to see the degree of congruency amongst the nurses.

I often reflected on my choice of questions created for the semi-structured interviews. Although I had piloted the question set with two international colleagues beforehand, I was surprised at some of the responses. Some people seemed more articulate in their answers to the questions, while others offered seemingly socially desirable responses. I noticed how this impacted my ability to conduct interviews, becoming mindful of the semi-structured nature of the process, allowing time and space to explore with the respondents. My learning from this will carry to my next research project, where I will spend more time in creating the questions, reviewing them with colleagues and piloting them on a wider variety of people before implementation. I have learned that creating a survey tool that allows for a wide range of responses using open-ended questions is crucial to ensure a breadth of information is found.

From completing this research, I feel that I have become more adept in my ability to work with nursing colleagues, exploring and reflecting together with them to improve a mutual understanding of their experiences.

I have noticed how this experience has made me more aware of myself when engaging in conversations with other nurse learners who are struggling. I have become aware of how my body language and choice of words can facilitate or impede a sensitive conversation or interview. While I have previously held management positions, I have developed greater empathy for the lived experience of migrant nurses and an awareness of assumptions and bias that I previously held. In my current roles as Programme Leader at Otago Polytechnic and Workforce Facilitator at Te Whatu Ora, my learnings are perhaps influencing the attitudes and biases that others have towards international nurses. This was evident in a series of workshops I co-ran with nurses at Mercy Hospital. I have also been asked to speak on working with international nurses at several clinical areas around Dunedin Hospital. These have provided me with opportunities to share my learning around the needs of international colleagues and even highlight how bias and stereotyping can impact existing work-based relationship issues.

Perhaps the most moving experience was the interview with the respondent who talked about their negative experience in the CAP (see Appendix F). This person had previously failed the CAP and he spoke in depth about the impact that this experience had on him as a person and a professional. My interview with him went twice the usual time. He spoke of the humiliating way he had been treated and related his precarious, downwards journey to failure. This caused me to reflect on the CAP students who had been unsuccessful in the past and on how I had managed those experiences. I had known this nurse in their capacity as a
registered nurse for several years, having worked with them as they supported undergraduate students. Although, I had known that he had been a CAP graduate, I had not known he had such a negative experience. This nurse has taught me a great deal about how important it is to make a clear way ahead for the migrant nurse undergoing professional assessment. So often, nurses set expectations of learners that are not made explicit from the outset, and this can end in confusion and disorientation during the clinical placement. I now use this nurse’s negative clinical placement experience during my presentation at the Preceptor Course. The nurse felt very strongly that others should learn from his bad experience – this was the reason he gave for participating in my research project. He gave me permission to use his experience as a teaching example in the Preceptor Course run by Te Whatu Ora.

Previously, my presentation had focused on all the positive things that registered nurse preceptors can do. I now add in this ex-CAP nurse’s negative experience and focus on how many of his needs were not met. For example, there was a lack of planning in the six weeks that he spent on the ward. He was unaware of what the expectations of the preceptor were, with inadequate communication around concerns that the preceptor was holding. There was a lack of clarity in expectations and avoidable communication barriers with little recognition of cultural differences. This part of the presentation has proved popular as preceptors consider the impact they can have on international peers undergoing assessment.

I have also learned to signal early to CAP candidates when things are not going well. I have started to use the Record of Concern mechanism early – this allows for the documentation of concerns, involvement of International Student Support and clear goals and expectations to be mutually agreed upon. This experience has also made me a stronger advocate for nurses who I believe are having unfair assessments and experiences in the clinical setting. Since my interviews, I have had several challenging conversations with preceptors since my interviews, where I have identified an unfair, bias assessment process going on. I have realised how vulnerable international nurses are and the importance of monitoring the assessment process in the clinical setting to ensure safety for the international nurse.

My Journey as a Nurse Educator

While I have worked in nurse education for the past 14 years, I have noticed a period of significant growth during my MPP journey, particularly in the areas of reflective practice, professional relationships with learners, empowerment and needs assessment. Reflective practice is something that is required of registered nurses by the NCNZ. It is something that I have been practicing for a long time. However, my focus had been on the learner’s reflective practice and not my own.

My regular meetings with my facilitators provided an opportunity for me to develop courage and confidence in better understanding myself. I delved way back in my life, examining my
thoughts and feelings around situations where I was the learner. I was able to see how my own early learning experiences had shaped the type of dual professional I had become. I now realise that learners are impacted by many different sources and forces of influence. For example, I was able to understand how previous chapters of my life such as, early music education (performance learning), studying psychology at university (motivation and human behaviour), and entering a profession of caring and working in different international settings, had influenced my professional self today. I was able to make a connection between learning at formal institutions and work-based learning throughout my nursing career.

I now value the importance for nurse educators to be able to understand their own learning histories and, therefore, better understand nurse learners. Migrant nurses come from often very different and complex backgrounds that are not necessarily known or similar to their New Zealand peers. In order to be able to understand the impact of developmental, socio-cultural and educational experiences on a nurse, one has to be able to understand oneself and what contributed to one’s own professional stage. I was particularly interested in the concept of reflexivity as described by Christopher Johns (2003), a reflective nurse educator. Reflexivity is the process of incorporating previous experiences and, thinking within experiences, seeking to gain a better understanding of oneself and one’s impact within an experience (Bolton & Delderfield, 2018). Now, my own reflecting looks deeper, asking myself questions such as, “why do I look at this aspect? What impact does past experience have upon perceptions? and how do my values, beliefs and emotions impact upon my experience?

Reflexivity is something that I wish to continue to explore and is beginning to appear in my sessions with CAP students. I am fascinated that nurses from particular countries have no experience of reflection. My interviews revealed that, for some, the notion of reflection is associated with confusion, frustration and even for one nurse, physical pain. I would like to explore how I could assist international nurses to begin their own journeys in reflection since it is such a key aspect of nursing in New Zealand.

Challenges
A number of significant events have occurred during my MPP journey. Early in Course 2, my father’s health deteriorated. He had been living with dementia for some time but deteriorated quickly, necessitating my involvement since he had appointed me his enduring power of attorney for his health and welfare. This involved hospital visits, advocacy and eventually, arranging for his admission into secure aged residential care. Over the following months he suffered further deterioration and died. The enormity of this life change, the loss of a parent, was something I had not anticipated.

Many of the IQNs I have worked with, having left their families at home to build a new career and life in a faraway place have experienced the loss of a significant family member. I can recall numerous occasions when students told me of the death of a parent or sibling and not
being able to return to fulfil family obligations and grief journeys. I have found a new appreciation of the impact that death within the family can have upon a nurse learner who must continue to struggle to reach their professional and educational goals, despite such hardship.

I would also experience a significant medical emergency during the writing of my research report. A descending curtain of blackness across my right eye was diagnosed as a retinal detachment. This very scary experience meant I was restricted in reading and eye movements for several weeks. Once recovered and retina healed, I realised as an educator, how important our vision is, but also, felt an empathy for patients who experienced similar medical events threatening everyday abilities that we take for granted.

I have noticed, in my role as Chair of the School Assessment Committee, how I have become more empathetic to undergraduate students who have struggled with personal family and health issues. Previously, I was perhaps less acquainted with personal crises and the challenge of keeping up with educational commitments as one navigates illness and grief. Through my own experiences, I feel that I am able to make more informed decisions around requests for impaired performances, extensions and altered education pathways. This has been a valuable contribution to my role as a senior educator, and augmented my decision-making ability around supporting other nurse learners who struggle on their journey.

Another major challenge was the impact of a global pandemic, impacting everyone’s ability to move about and even communicate with others in ways we were familiar with. All teaching had to suddenly move online, and the closure of the international borders had a major impact upon the CAP. This was a time of great uncertainty and anxiety for many: learners, teachers, and researchers. I needed to put my MPP aside temporarily, as I answered the emergency call for registered nurses to become mass vaccinators. This required substantial hours of online education about the Covid-19 virus and the use of a controversial mRNA vaccine. A mass vaccination clinic was set up in central Dunedin and I spent many hours vaccinating hundreds of people against the Covid infection. My participation in the mass vaccination project went on for about a year. It was wonderful to work with all sorts of registered nurses as well as nursing students. The call had gone out to all registered nurses who were both practicing and those whose practicing certificates had lapsed. I was also involved in the recruitment of a substantial number of Year III Bachelor of Nursing students who joined us as Provisional Vaccinators. It was inspiring to work alongside both retired colleagues and budding neophytes who all showed courage and determination to protect the public safety.

It was an important link between Otago Polytechnic and the community – connecting education with the public who were commonly scared, unsure, and grateful of the care we gave. I learned that during such public health emergencies, nurses and those whom they work with, need to have a sense of community. The comradery of the mass vaccination centre
reminded me of the human need for love and belonging. Nurses developed strong bonds with each other and were extraordinarily supportive. Those who had been out of practice for some time were well supported by those currently working at the hospital. Nurses shared stories of previous experiences in crisis situations. Despite the inherent risk to staff from so much exposure to the public during a pandemic, the staff drew strength from each other. The public’s response was overwhelmingly positive and full of gratitude. This experience has taught me the importance of believing in nurses in the CAP who have not practiced in a long time; the need for the recovery of their professional esteem and to feel valued and worthwhile directly impacts on their clinical performance. This had informed my attitude towards ‘return to nursing’ students – to provide extra opportunities for recognition and encouragement – culminating in a dedicated graduation that includes their friends and families. The attainment of registration and the reclaiming of a Practicing Certificate is the equivalent of Maslow’s self-actualisation. The nurse feels fulfilled, proud and accomplished. The nurse has a new awareness of self and their ability to practice as a contemporary nurse.

Another challenge during my MPP journey also related to the impact of the global pandemic. The closure of international borders had severely limited the inflow of IQNs. The aged residential care sector is heavily reliant on international nurses. This unanticipated disruption to the inflow of IQNs started to have dire consequences to staffing in facilities that provided care to the elderly across the region. The Director of Nursing at the, then, SDHB, responsible for the provision of aged care, approached me and asked if I could help with an identified latent workforce of IQNs who were not able to gain nurse registration in New Zealand. I feel that this approach was an acknowledgement of my expertise with international nurses and registration. Having worked previously for the NCNZ, I had a unique insight into the registration process for internationally qualified nurses.

I have been working for Te Whatu Ora Southern as a Workforce Coordinator. A group of 150 IQNs, currently working as health care assistants in the aged residential care sector had been identified from a workplace survey. These people had not met the standards for registration and my role was to prepare a case for each nurse for the NCNZ to consider. I enjoyed setting up this important project, creating relationships with each nurse, their manager, as well as liaising and reporting to the Director of Nursing and the NCNZ. I feel that the MPP journey has given me skills and confidence in relationship building, across the education, health provider and nursing regulation sectors.

I have been able to draw upon my learnings from my research into the needs of nurses, to be able to build cases whereby employers could demonstrate their ability to support IQNs and reassure the NCNZ of the safety of these nurses who would be considered for registration. As mentioned earlier, the nursing workforce is in a state of crisis, and roles such as this are critical to supporting this health care profession. My work in this role has been recognised in the Otago Daily Times (the local newspaper) as a positive initiative of the SDHB’s efforts to sustain
nursing in the region. I have also been approached by Te Whatu Ora Canterbury to consult with them on how they could establish a similar role for IQNs in the Canterbury region. This role of international workforce coordinator has given me a unique insight into my research. My regular contact and conversations with nurses as well as their employers has augmented my understanding of the esteem needs. Many nurses have expressed their appreciation (sometimes whole families in tears on Zoom calls) and talked about how bad they have felt, not being able to work as a nurse in New Zealand. One nurse told me of how he had been depressed for many years, while working as a health care assistant. He reported feeling worthless and under-recognised. He had been an intensive care nurse previously, but not being able to attain registration had impacted his self-esteem. He has come through my support project and the CAP is now working as a highly valued intensive care nurse.

Another important outcome has been the collaboration I established with the English Language Centre at the University of Otago. For many of the IQNs in the Te Whatu Ora project, English Language proficiency was an significant barrier to being eligible for registration. Through meetings with the director and teaching staff at the English Language Centre, we have set up a bespoke programme that prepares international nurses to take the OET test. This collaboration has been recognised as an important Te Whatu Ora-sponsored initiative that has led to a significant number of nurses passing the OET test and moving on to registration.

I have found the past year challenging, yet hugely rewarding, working in three roles: educator, researcher, and workforce facilitator. They have given me the opportunity to realise a new framework of practice where the needs of international nurses are at the centre.

Change is occurring at an unprecedented rate as global events develop. This change has an impact on nurse migration and, in turn, workforce replenishment in the health care sector. I have learned how to respond to organisational change within my roles as the Southern District Health Board transforms into Te Whatu Ora Southern, and as Otago Polytechnic became Te Pūkenga. My MPP journey has taken me through changes in organisations. In turn, I have learned to appreciate the enormous amount of change and uncertainty that migrants go through. Many of the needs deficits in migrating nurses relate to change and uncertainty around home, work, family, and the future.

**Progressing into a consultant role**

I had not previously considered myself an expert in the area of international nursing until I embarked on my MPP journey. While I am well-known around the Dunedin health care sector from my role as Programme Leader of the Competence Assessment Programme, my research project further raised my profile amongst nurse leaders. I approached the Chief Nursing and Midwifery Officer, Jane Wilson, for permission to have access to internationally registered nurses working in Dunedin Hospital. Concurrently, I approached nurse managers in all aged

Practitioner Thesis
residential care facilities in Otago to be able to advertise and recruit participants for Group B. I was amazed at how important nurse leaders felt my research was. Soon, international nurses themselves were communicating informally with each other via social media about my research.

**Advocacy: Giving Voice to International Nurses**
While my original intention was to better understand what IQNs need as new arrivals to competence assessment and nursing, it soon became apparent that there was another significant aspect to my research project. I was surprised at how eager people were to participate in my study, once they became involved through the interviews. Most people from Group B, those who had been through a CAP and had been working since, seemed to reflect back very positively on their experiences. While another recent study has not supported this (Clubb, 2022), my interviews found, for the most part, nurses felt their CAP journey was valuable and made a significant difference in their transition to nursing in New Zealand. I learned that two very similar studies can produce quite different results. I had previously discussed my own study design with Clubb and there were similarities between our approaches. I had begun to realise that my study had actually given a voice to nurses who had previously not been asked about their experiences and, in particular, what they felt new IQNs needed. Many times, I was thanked by participants for considering the international nurses’ perspectives and word seemed to spread through informal social networks that I was speaking up on behalf of IQNs. My research was value-laden in that I sought to provide a voice and empower this group of nurses who historically had been unacknowledged and seen as an unfortunate consequence of nursing shortage.

**Reviewing My Learning Outcomes**
I have demonstrated my ability to identify an area of enquiry, relevant to my dual professional roles of nurse and educator.

I have considered the educational needs of international learners through the examination of international nurse learners’ experiences in the competence assessment process. I have become aware of the pedagogical differences between the Asian nurse education systems and the New Zealand context. I have been able to make changes to current CAP that has been informed by information gained from my research. For example: incorporating an internationally qualified, previous migrant nurse into the End-of-Life Workshop. CAP candidates have spoken of the value of having a nurse from their own country speak about the moral dilemma commonly found when providing palliative care.

I have reviewed the curriculum of the CAP and adjusted topics in acknowledgement of responses from participants in my research. I have also consulted with other CAP providers to benchmark the Otago Programme’s content to ensure consistency. IQN candidates spoke, for instance, about the difficulty they have in interacting with New Zealand health care
assistants in the workplace. I collaborated with an expert in the Settlement and Protection Unit of Immigration New Zealand and together we now run an evidence-based workshop within the CAP that looks at cultural differences amongst health care staff and how to work collaboratively. This workshop has been shared with other CAP providers and incorporated into their curriculum.

I have developed skills in professional network development throughout my MPP journey. It commenced with connecting with nursing leaders at Te Whatu Ora to inform them of my research and gain access to be able to recruit participants. This, in turn, raised my profile in the sector and, in particular, international nursing. I have joined with nurse leaders to create regional guidelines to support IQNs post-registration, in the initial employment period. This role was informed by my research into nurses’ needs and my understanding of the type of support they need to be provided in order to succeed.

While one of my aims was to be ready for a conference presentation to disseminate my findings, the unanticipated change in roles has impacted my time to be able to attend and participate in a professional conference. Nonetheless, I am planning to deliver a presentation at the College of Gerontology Nursing in May 2023. My focus will be on the needs of international nurses who migrate to New Zealand and how the aged care sector can support international staff leading to improved recruitment and retention (a situation that is currently in a state of crisis).
My final professional practice learning objective related to developing an advisory role in the area of international nurse competence. This has been demonstrated in several areas. I am currently a member of a reference group, advising the NCNZ on proposed changes to the assessment of competence of international nurses. I am co-coordinating a national Te Pūkenga forum in 2023 to examine how the organisation might position itself within a revised competence system. I have been a part of a senior nurse leadership group that has published a guideline for employers of internationally qualified nurses. I continue to provide advice and guidance to nurse executives in Te Whatu Ora Southern in the support and development of internationally qualified nurses in both the hospital systems and aged residential care sector.

Figure 15
My New Framework of Professional Practice (author’s own)


Jenkins, B., & Huntington, A. (2016). “We are the international nurses”: An exploration of internationally qualified nurses’ experiences of transitioning to New Zealand and working in aged care. *Nursing Praxis in New Zealand, 32*(2), 9-20.


Schorpp, M. M. O. (2008). The relationships among perceived importance of educational needs, satisfaction with the educational experience and self actualization of senior baccalaureate nursing students: An application of Maslow’s hierarchy of needs theory [PhD Thesis]. Widener University School of Nursing.


Appendix A. Reflection on a Failed Participant

Participant ‘Jay’.

One interview from group B took me by complete surprise. I will use the pseudonym, ‘Jay’ in reference to this participant. Jay was an internationally qualified registered nurse who I had known for several years. He had preceptored many undergraduate nursing students as well as CAP candidates for registration who I had been supervising at his clinical workplace. Jay always seemed ‘upbeat’ and very positive about his nursing career. I was delighted when he contacted me, responding to my participant recruitment advertisement; I’d known nothing about his own previous CAP journey and would discover that his was very different to the other participants. Jay had failed on his CAP programme at Otago Polytechnic.

Jay introduced his CAP journey as having been an ‘interesting experience. He was an experienced acute-care nurse from overseas and enjoyed the first two theory weeks of his course. He was placed in an aged residential care (ARC) facility for his six-week clinical practicum where he would be assessed against the registered nurse scope of practice. Jay had a regrettable experience over the six weeks which was extended by a further week. He was informed at the conclusion that he had failed the course. Jay related that when he saw my recruitment notice, he felt this was his opportunity to share his story, express his concerns and in turn, make a difference for other candidates for registration.

While not seeking to avoid responsibility for his performance during the seven-week clinical experience, Jay wanted to share several contributing factors that could lead to recommendations for change. Jay felt he did not receive an adequate orientation to the aged care facility. The preceptor did not seek to get to know him professionally or personally at the outset of the relationship. Jay had no experience of aged care or how such a facility ran. He was not oriented to the physical layout or the residents but felt he was simply left to fend for himself. Jay felt his preceptor hardly communicated with him, leaving him feeling confused, unsure, and lonely. There was not encouragement, reinforcement, or guidance around clinical performance expectations. The relationship between Jay and his preceptor progressively deteriorated over the period and the clinical lecturer became involved at week 3, the midway point. It was not until this point, that Jay was informed that he his performance was inadequate and that he lacked initiative. Jay didn’t understand this word and felt that the lack of communication and guidance and left him unable to progress towards a more responsible mode of practice. Jay reported experiencing prolonged, sustained feelings of stress and anxiety. He had used all his, and his family’s life savings to fund the programme and when he was told at the conclusion that he’d failed, he was devastated. He was on a temporary visa and did not know how he would be able to continue in New Zealand as a failed CAP candidate.
Jay found a supportive nurse manager in an alternate ARC facility who employed him as a health care assistant and assisted him with obtaining a work visa. After a short period of time, Jay re-enrolled in the same school of nursing to reattempt the clinical practicum component. He was placed with a different facility and, a different clinical supervisor – his experience was completely different. Upon reflecting on these differences and, having worked as a successful and popular nurse preceptor himself, he offered the following recommendations for preceptors:

- Preceptors should have completed formal training in their role.
- Get to know registered nurse candidates undergoing assessment at the beginning: find out about their professional background and experience but also about their personal circumstances (many have often left children and partners behind and worry about them).
- Let the candidate know about yourself as an RN preceptor – your own clinical experiences, how you like to precept and how you like to assess.
- Provide a plan of how the six-week placement is going to run – how feedback will be given, what type of clinical experiences will be provided, what the expectations are and how they will change over the duration of the placement.
- Be clear and explicit with candidates – consider their newness to the country as well as the health care system.
- Provide opportunities for the candidate to demonstrate specific aspects of competence, for example, encourage the candidate to participate in end-of-life care to be able to demonstrate therapeutic relationships and communication.
- Clinical supervisors should visit weekly and provide regular feedback on how the placement is going and if expectations are being met.
- Clinical supervisors should recognise early, when candidates are struggling and initiate support referrals to meet the needs of international learners who are struggling.
- Above all, take an individualised approach to the candidate, getting to know the candidate and therefore, understanding their needs. Do not prejudge a nurse undergoing assessment but provide appropriate, realistic clinical opportunities and time for the nurse to be able to adjust to the clinical setting and recover their professional self.

The outcome of this interview will make a difference in the preparation of subsequent registered nurse preceptors working in the Southern region. I received permission from Jay to use his experience as a teaching example and have begun to incorporate it in my sessions at the Te Whatu Ora: Southern Preceptor Training Course. Early feedback from attendees is that they are moved, saddened yet inspired to provide a better quality of preceptorship that what Jay received (see Appendix K). They have seemed surprised yet ‘illuminated’ about the needs of international nurse undergoing CAP assessment and I have noticed numerous ‘a-ha’ moments amongst attendees.
Participant Jay has been able to make a significant contribution to my enquiry into the needs of international nurses and help better prepare those who precept and assess them.
Appendix B. Survey Questions for Group A.

Survey Questions for Group A — CAP candidates enrolled in course.

1. How many years since you graduated with your bachelor degree in nursing?
2. How long have you been in New Zealand for?
3. Have you worked as a Health Care Assistant in New Zealand — how long for?
4. What countries have you previously worked in?
5. What were your reasons for coming to New Zealand to work as a registered nurse?
6. What do you think are some of the differences in the role and practice of nurses in your home country compared to nursing in New Zealand?
7. How would you prefer to have your competence assessed?
8. What information should be part of the content of a CAP course?
9. You have been sent a set of pre-course readings. Did you complete these before arrival?
10. What are your preferred ways of learning?
11. How long should the theory part of the course be?
12. How long should the practical part of the course be?
13. What does ‘Critical Thinking’ mean?
14. What do you think your physiological needs are?
15. What do you think your security needs are?
16. What do you think your social needs are?
17. What do you think your esteem needs are?
Appendix C. Interview Questions for Group B.

Interview questions: Group B: NZ registered IQNs

1. What country are you from and how long since you trained as a registered nurse?
2. What can you remember from your CAP programme?
3. How long ago was your CAP programme?
4. How long had you been in NZ before your CAP programme commenced?
5. What topics should have been included in the CAP programme?
6. What topics did not need to be included in your CAP programme?
7. What teaching/learning methods do you like and should be in a CAP programme?
8. How well did the CAP prepare you for working in NZ?
9. Where were some of your greatest challenges as a newly-registered NZRN?
10. Are the right things being assessed in competence assessment?
11. As you reflect back on your CAP experience, is there anything else you would like to add or contribute?
Appendix D. Example of data analysis from Group A.

Question Five in Full Text

Participant Responses

1. I really want to learn other things apart from the current learnings I have. And if given the chance, I would like to study something new here in New Zealand apart from Nursing.

2. To start a family.

3. My plan was to work overseas whether New Zealand, Australia or England. I decided to come to New Zealand because of its way of living which is very relax than most of the other countries. I like its vibe and I would really like to settle here in the future.

4. The main reason why i opt New Zealand is to explore an European country experience secondly, my husband and me came to know that it's the best place to live as a family.

5. Career development. I wish to broaden my knowledge with the nursing profession. I want to become a better nurse, not just for myself, but also for my family.

6. I think New Zealand is one of the beautiful island in the world where a nurse can work safe and secure. I personally believe that the people in New Zealand are very expressive and kind hearted to accepted those people who migrate. Especially for nurses who get support at employment(rights). Moreover, New Zealand provides a variety of benefits for migrant people like education and schooling, safety, health care facilities, permanent residency and so on. This is why I prefer New Zealand as my destination as a Nurse from India.

7. this is a safe place to live with family. Here people give respect to my profession and it is well paid.

8. First of all to look for a greener pasture. Every nurses I believe deserves the best quality of benefit not only for professional growth but also on personal interest is served. Secondly, my sister lives here for almost 5 years. We haven't seen each other for almost 3 years already and it would be nice to be here working for good. New Zealand above all country I've been to, the people here are the best I've known and they have the warmest smile I ever saw.

9. Firstly, I want to work in New Zealand. Hopefully, I will get a job soon and after a couple of months, my target is to get my husband and 3 kids together with me. I want to live here with my whole family because I believe that New Zealand is a family-centered country.

10. To be acknowledge as professional and to be able to provide better future to my family.

11. I believe nurses have more dignity and respect in New Zealand than my country. I would also like to get more work experience from a developed country like New Zealand.

12. The compensation/salary of nurses in Philippines is very low. Heavy traffic in Philippines and the weather is getting hotter. I want to bring my family especially my son in an English country.

13. This is my first time here in New Zealand. There is so much to offer here than where I came from. Initially, I chose to come here to study and become a registered nurse but the longer I was staying here, the different culture that I have encountered, became a very important aspect of my way life and its a very great experience, learning new ways in all ways. Also, another reason for coming in New Zealand is because of my family. I want to give them an experience of greener pasture where we can never experience it in our own country.

14. I would like to explore the beautiful country.

15. I would like to work as a registered nurse in New Zealand.

16. Better safety and social security, further studies, and financial stability.
17. Firstly, I wish to work overseas especially in an English speaking country. Secondly, I always want to get more career opportunities and also good renumeration. In addition, I will get an opportunity to interact with people who comes from different countries and cultures.
18. Its my dream to work such a beautiful country where everyone treats nurses with respect and dignity.
19. First of all, New Zealand is a good place to settled and heard that vacancies are aplenty of for nurses. The others factors are Respect which I will get in clinical, Salary, resident options and salary.
20. I believe than New Zealand gives us better opportunities in general. The compensation that we will get is much better than were I came from.
21. For better carrier opportunity

Themes/Codes
To learn (professional development / personal development) n=8
Family n=8
The New Zealand lifestyle (change in lifestyle)
To explore a different country/culture n=6
Safety n=4
Opportunities (education/healthcare)
Respect n=4
Salary
Appendix E: Example of Interview Transcription From Group B Participant

Transcript of Participant:

(1) What country are you from and how long since you trained as a registered nurse?
(2) I’m from India, the southern part called Kerala. I’ve been trained as a registered nurse for four years.

(1) how long ago did you do the CAP programme at Waiairiki?
(2) It was two weeks theory and three weeks practical so total of five weeks. That was in 2012. 8 years ago. My placement was in a rest home.

(1) what did you think about your placement in a rest home
(2) it was very challenging for me because I hadn’t had any rest home experience previously. Initially it was, I was totally blind, where to start. I haven’t seen any blister packs before. Not even the hoist.

(1) Did they show you the hoist in the first two weeks?
(2) No they didn’t show us how to use a hoist nor how to transfer.

(1) What do you remember from that CAP experience?
(2) It wasn’t too overwhelming for the theory because there was only minimal requirement for us to meet, only the medications and the practical NGT tube assessments, all those things. But when I went to the practical, I felt like they might have included all the ..... you know they might have shown how the blister packs looked like, they might have shown like how to use the hoist because I wasn’t familiar with all those things when I went to the resthome. Theory: we haven’t had like much requirements to complete during the theory time, only the medications 10 to 20 I think the objective type of questions, for the medications which was okay. Before that they had given so many practical tests like can do at home. So that was good. The second was the OSCE which need to complete the theory and was also good, because we know the procedures like NGT tube, history collection, physical examination, IV – all those things. I only had to do one of those things in the OSCE. Before the OSCE, they have a practical thing, we can do it. Because we know what the practical is. But when I went to the resthome, that was challenging for me. I had no idea about the whole place. I didn’t come from a background like that. The preceptor she was absolutely good. She helped lots, especially with the international students – she taught us how to behave and also the jargons which was another thing – we just only know how to speak the normal English – we don’t know what the Kiwis use in their speech “box of fluffy duckies” and all those things. She give us an idea of how Kiwis talk and what it means. She told us how to prepare for the practical setting like make sure that you wear the correct uniforms, what to expect from the patient at resthomes.

(1) Was it a shock when you came here from India?
(2) I was confident in the theory, that I can make through it – I know but when I saw the resthome, it was shocking – I had no idea.

(1) How could you have been better prepared for that?
(2) I did not know what a resthome is. Maybe they might have arrange a class to show us a video or something about how resthomes look like and the equipment’s like hoists and how we transfer the patients. How the medications come like this, in a blister pack and I wasn’t sure of the role of the nurse there.

(1) How long had you been in NZ before you started the CAP programme?
(2) I just came for direct CAP – that was the other problem for me. I hadn’t been a carer or anything – I just came direct. It was a shock.

(1) how long did it take you to feel comfortable here after you arrived? When did you start to feel comfortable.
(2) When I went to Wairiki polytechnic, I had friends who stayed with me – but when they put the postings, we all got divided. I went to Tauranga so that was a hard time for me – I didn’t know anybody there and had to find accommodation there. There was no other option.

(1) Did they do anything at the polytechnic to help the students to feel okay ?
(2) Yes, they got some of families who offer accommodation, they gave like a list you could call and ask them. It was a helpful way for me to arrange accommodation. Only 3 or 4 only came directly to the CAP, most of the students were here before, doing infection control programme, English course. Only myself and two others came directly.

(1) Is there anything that could be done better to support those new arrivals?
(2) Maybe if they can arrange the accommodation by the Polytechnic itself for the CAP students. And ask they, if they are posting them in a resthome facility, give them an idea about how it looks like.

(1) what about knowing where to buy the food that you like?
(2) I had a backpackers accommodation for the theory time so the receptionist gave me a map and told me where to go. Even though it was quite hard, we had got so many people staying at the same backpackers – we supported each other.

(1) When you think about the topics that were in the two-weeks, what things should they have included that would have been helpful for the nurses.
(2) I think that tikaka – because I have seen here that it is very good- the guidelines. We didn’t have as much elaboration or what you are giving here, compared to up there. I think that might be a better idea if they can explain tikaka to the students. It was too brief in my course. We also had – if they can give something like presentation for the students, it might help the students to come up and talk, mingle with everyone and the way they present. Give them some confidence to come up front and talk. If they can give a presentation. To encourage them to speak and have confidence – to boost their confidence.
I know that some of the Dunedin students they do the drug presentations during their practical and they give the inservice to the caregivers. But we didn’t have that in my programme.
Appendix F: PowerPoint Presentation to MPP Assessment Panel
An Exploration of the Needs of Migrant Nurses Undergoing Competence Assessment for New Zealand Registration

Master of Professional Practice Course 3: Part Two: Oral Presentation

Geoffrey Harvey RN MN (Adv. Pract.) MAcadMedEd
1. About me
2. Motivation for enquiry
3. Context
4. Research methodology
5. Research findings
6. Learning outcomes
7. Framework of professional practice
8. Impact
9. Where to from here
About me...

-----

Registered Nurse
Tertiary Educator
Researcher
Consultant

(Reproduced with permission)
Motivation for Enquiry

International experience
Desire for change and improvement
Fairness and empowerment
The Preceptor Course at Te Whatu Ora: Southern
Professional growth and development
New directions: Nursing Council NZ
Human needs
Context

The Nursing Crisis

- Reliance on international nurses (IQN)
- Global pandemic
- Aging workforce
- Assessment process barriers
- International competition

Number of nurses who have joined the New Zealand register 2017 - 2021,
(NCNZ, 2022) - REDACTED
The literature...

- Nurse migration
- Nurse migration to New Zealand
- Nurse’s experiences
- Isolation
- Communication
- Differences in practice
- Marginalisation
- The Maslow Hierarchy of Needs
Research Methodology

Research Design

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<td>Constructivist</td>
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| Research methodology      | Case Study        |

| Research methods          | Survey            |
|                           | Semi-structured interview |

Evolution of focus: curriculum to needs
Research Findings

Figure 8
*Reasons For Migration (author’s own)*

Figure 9
*Differences Related to Nursing Practice (author’s own)*

- Responsibility
- Communication
- Scope of Practice
- Differences in Nursing Role
- Legal/Ethical
- Cultural
- Skills
Figure 13
Nurses’ Definitions of Critical Thinking (author’s own)

- Composed and relaxed
- Successful
- A sense that the nurse should have
- Proactive and openminded
- Acting wisely

Characteristics of a good nurse

- Drawing on the past
  - Logic
  - Objectivity
  - Precision
  - Analysis
  - Clinical judgement

Cognition

- Able to act fast
  - Able to think quickly
  - Able to interpret quickly

Emergencies

- Validation of correctness of decisions
- Avoiding harm
- Keeping patients safe

Quality
Research Findings

Group B

Identifying the themes

- Previous educational experiences
- Reflection
- Content
- Understanding the language
- Being understood
- Accommodation
- Preceptor
- End of life care Discrimination
- Culture shock
- Talking patients
- Interprofessional relating
- Fear
- Quietness
- The CAP Voice
- Therapeutic communication
Migrant Nurse Needs

Respect
Professional recognition
Career development
Acceptance
Confidence
Self-esteem

Esteem

Love and Belonging

Physiological Needs

Safety Needs

Employment
Financial security
Personal security
Stay healthy
Fair and equitable professional assessment
Adequate professional preparation

Accommodation
Familiar food/clean water
Sleep
Warm clothing
Clean air
Transportation

Family opportunity
Communication guidance
Classroom community
Cultural integration
Friendships
The Prism Model of Migrant Nurse Needs

- Acknowledgement of previous clinical experience
- Recognition of nursing education
- RN Candidate rather than student
- Freedom to make mistakes
- Need to succeed

PROFESSIONAL FULFILMENT
- Competent nursing care

CULTURAL INTEGRATION
- Freedom from exploitation
- Safe accommodation
- Access to health care
- Employment opportunities
- Environmental safety

THE MIGRATING NURSE

Esteem
- Affordable accommodation
- Familiar food supply
- Safe drinking water
- Appropriate clothing

Love and Belonging
- Social connections at work
- Contact with family
- Family reunification
- Connections with own culture

Physiological needs

Safety needs
“Nurse keen for placement after difficult journey.”
Otago Daily Times, 23 March 2021 - IMAGE REDACTED
My Learning Outcomes

1. Research proficient
2. Transcultural education proficient
3. Curriculum review proficient
4. Professional networking proficient
5. Publication/conference presentation ready
6. Competence advisor
Framework of Professional Practice

The new me...
Professional Practice Impact

- Contemporary, evidence-based Competence Assessment Programme
- Evidenced-based training for registered nurse preceptors
- Co-leading Te Pūkenga CAP Forum on future programmes
- Secondment to Te Whatu Ora – International Nurse Facilitator
- Identification of barriers to IQN registration
- Consultant role with Nursing Council NZ: system change
- Consultant role with Te Whatu Ora/Health New Zealand
- The Prism Model of Migrant Nurse Needs -hospitals
Where to from here?

- The end of CAP
- Te Whatu Ora and Te Pūkenga
- Premigration stories
The International Nurses

Nga mihi
Ko te pae tawhiti, whāia kia tata; ko te pae tata; whakamaua kia tīna

Seek out distant horizons and cherish those you attain

(Alsop & Kupenga, 2016)