The Experiences of Internationally Qualified Registered Nurses Working in the Australian Healthcare System: An Integrative Literature Review

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Abstract

Introduction: International nurses account for 20% of the Australian nurse workforce. This review aims to identify and appraise research findings on the experiences of internationally qualified registered nurses working in the Australian healthcare system.

Methodology: The review was structured using Whittemore and Knafl modified framework for integrated reviews. A systematic database search was undertaken. Articles (n = 48) were identified for appraisal based on set inclusion and exclusion criteria. Evaluation using the Critical Appraisal Skills Program tool resulted in (n = 16) articles in the final data set.

Results: Three broad themes were identified: (a) Transitioning—Need for appropriate, timely, and adequate supports to assist transition to practice; (b) Practicing within local contexts—How expectations were different to the reality of clinical practice; and (c) Experiencing prejudice—when racial prejudice occurred.

Discussion: Appropriate programs including cultural-safety education can mitigate adverse workforce dynamics within culturally diverse health care teams to enable provision of culturally congruent health care.

Keywords

Australia, health care system, internationally qualified, registered nurse

Introduction

In 2015-2016, there were 657,621 registered health practitio- ners in Australia. Nurses and midwives represented the largest sector at 57.8% of the health workforce (Australian Health Practitioner Regulation Agency, 2016). There is currently an increase in demand in Australia's health labor market due to "Australia's ageing population" and the "implementation of the National Disability Insurance Scheme (NDIS)" (Department of

Employment, 2016, p. 2). In 2017, there were 492 community nursing care groups approved by the NDIS to provide care to individuals registered with the scheme with high-care needs (NDIS, 2017). Internationally qualified registered nurses (IQRNs) have been recruited to fill nurse workforce shortages in Australia and make up approximately 20% of the registered nurse (RN) workforce (Australian Institute of Health and Welfare, 2014).

The provision of health care to meet the needs of individu- als and communities is complex. Health system resources include the workforce, infrastructure, medical technologies, and access to medicines. Contemporary global issues include the impact of disease, health needs in low-resource settings, vulnerable populations, environmental health issues, sustain- able workforces, and complicated matters in areas of conflict (Breakey, Corless, Meedzan, & Nicholas, 2015). Ethical con- cerns include equitable and just resource allocation, the influ- ence of technological and biotechnological advancements on the provision of care, and respect for diversity in cultures and values (Nicholas & Breakey, 2015). However, one of the most significant challenges for organizations globally, is managing human resources (Tarique & Schuler, 2010).

Projected and actual shortages of nurses and health care professionals affects countries worldwide, including Australia (Health Workforce Australia, 2014). Nursing short- ages in many developed countries have resulted in an increase in training positions and active recruitment of IQRNs to meet existing and future health workforce demands (Organisation for Economic Co-operation and Development, 2015). In Australia, the nursing skill shortage exists for experienced RNs rather than entry-level new graduates (Australian Institute of Health and Welfare, 2016). Recruitment of IQRNs occurs to meet demand in geographical areas of need, or areas of specialty nursing practice.

Migration of nurses is not new. Key reasons RNs migrate include improved career opportunities, lifestyle, travel, remuneration, or to provide economic support to their fami- lies in their country of origin (Newton, Pillay, & Higginbottom, 2012; Ohr, Parker, Jeong, & Joyce, 2010). IQRNs also leave their country of origin to escape civil unrest, war or persecution. Several countries including India, the Philippines, and China educate RNs who plan to migrate to work overseas postgraduation, including to Australia (Walton-Roberts, 2015). However, IQRNs must meet regis- tration requirements to be eligible to practice in Australia (Nursing and Midwifery Board of Australia, 2016).

All health professionals in Australia are required to be reg- istered with the Australian Health Practitioner Regulation Agency (AHPRA). AHPRA was formed in 2010 as the national body to regulate health practitioners in association with the national boards. The national boards are responsible for registering practitioners with the primary purpose to pro- tect the Australian public. Internationally qualified applicants are required to meet the registration standards of their profes- sion, which include the English language skills registration standard and the criminal history registration standard. Depending on the country of origin, additional requirements may need to be addressed by IQRNs seeking to work in Australia (Nursing and Midwifery Board of Australia, 2016).

Demand for health care professionals is expected to increase as population numbers increase, life expectancy continues to rise, rates of chronic disease increase, and the predicted impacts of an aging health workforce prevail (Stankiewicz & O'Connor, 2014). Understanding current recruitment and migration trends of IQRNs to Australia can inform policy directions, resource allocation, and assist with forward workforce planning to enable the successful integration of IQRNs into the Australian healthcare system (AHCS). Therefore, the aim of this integrative review was to identify and appraise research findings about the experiences of IQRNs working in the AHCS.

Method

Whittemore and Knafl (2005) modified integrative review framework was used to structure the review process as illus- trated in Table 1. The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) flowchart summariz- ing the screening process is presented in Figure 1. Data analy- sis was conducted using the qualitative method of comparative thematic analysis (Richards, 2015).

Electronic databases SCOPUS, CINAHL, and MEDLINE were searched for abstracts and/or full-text articles. The search strategy was formulated and executed systematically for each database using a combination of the following MeSH terms and keywords: registered nurse, nursing staff, foreign professional personnel, international nurse, interna- tionally qualified, overseas educated, foreign trained, quali- fication, education, trained, workforce, healthcare system, and Australia. Truncation was used to find variations of the same word stem, and phrase searching used inverted com- mas (" ") to prevent words from being separated. The

search terms were used alone and in combination. Boolean terms were used as conjunctions to narrow, broaden, or exclude terms. The use of Boolean terms to combine and/or exclude keywords ensured search results was focused and appropri- ate. Database searches were retained and saved to allow revision. Reference lists of key articles were hand searched for previously unsourced material to include significant arti- cles that may not have been systematically indexed with MeSH terms in the respective database. Subsequently, three articles were identified for further review. Inclusion criteria were developed and applied to the results to identify articles relevant to the area of inquiry (Table 2). Date limits were selected to reflect articles published after January 1, 2007 in response to the informal dialogue and global cooperation between governments on the effects of international migration (United Nations, 2016).

Methodological rigor of the eligibility of each article was also assessed using the Critical Appraisal Skills Programme (2015) appraisal checklist appropriate for the relevant research design (Whittemore & Knafl, 2005).

A Preferred Reporting Items for Systematic reviews and Meta-Analyses flow diagram was developed that summa- rizes the selection process used (Figure 1).

Data were analyzed using comparative thematic analysis (Richards, 2015). Data extracted from each article were coded for key incidents. The key research findings in each article were synthesized and summarized using a thematic analysis grid. These results are presented in the following section.

Results

Forty-eight text articles were appraised for methodological rigor, topic relevance, and legitimacy of the findings resulting in a final data set of n = 16 articles. Sixteen articles reported on internationally qualified nurses and their experience of working in the AHCS (Table 3). The studies collectively rep- resented participants from over 24 countries including India, China, Philippines, the United Kingdom, Scotland, Holland, Zimbabwe, the United States, Canada, Singapore, Malaysia, Japan, Korea, Nepal, and Africa. Nurses from culturally and linguistically diverse, or a non-English-speaking background (NESB) were cited in most studies. Nurses who migrate to work in another country were referred to as international,

overseas trained, immigrant, or overseas-qualified nurses with some studies using several lexes.

Three broad themes were identified from the analysis: Transitioning; Practicing within local contexts; and Experiencing prejudice.

Theme 1: Transitioning

Transitioning refers to the processes IQRNs undertake to integrate into a new health care system. The studies identi- fied that the integration of IQRNs into the AHCS involved complex, multidimensional processes, and players (Jeon & Chenoweth, 2007; Kawi & Xu, 2009; Wellard & Stockhausen, 2010). Organizations and health care institutions are respon- sible for providing policies and resources to enable IQRNs to transition successfully into the AHCS (Xiao et al., 2014). Key elements for this integration included sufficient organi- zational support, recognition of expectations by all parties, and comprehensive orientation programs (Dywili et al., 2012). In addition, an organizational approach that values and respects cultural diversity enabled IQRNs to transition successfully into the workforce (Brunero et al., 2008; Dywili et al., 2012).

Organizations and healthcare institutions expect IQRNs complete a transition and/or orientation program, to facilitate enculturation to the AHCS. Studies found programs tailored to meet the needs of individual IQRNs, taking into consider- ation educational background and previous experiences, were the most useful (Brunero et al., 2008; Jeon & Chenoweth, 2007). The IQRNs themselves expect efficient recruitment processes, an effective orientation, and initial and ongoing mentor support (Dywili et al., 2012) during the transition period. While all nurses found hospital and ward- level orientation programs helpful, IQRNs from a NESB rated the programs more positively (Brunero et al., 2008).

Several studies identified that nurse leaders need resources to facilitate the integration of international nurses into the AHCS (Jeon & Chenoweth, 2007; Xiao et al., 2014). Insufficient supports can compromise workforce integration and affect rapport between the international and local RN (Xiao et al., 2014). This is particularly evident for international nurses from a culturally and linguistically diverse or NESB. Australian RNs also require resources to facilitate IQRNs transition to the workplace (Jeon & Chenoweth, 2007). Resources include programs and activities that promote positive intergroup connections and inter- cultural

understanding (Xiao et al., 2014). Enabling welcoming environments, and acknowledging each other's background and experiences, increases both parties' understanding of diversity and strengthens bonds between existing and new staff members (Brunero et al., 2008). These strategies were found to encourage engagement and improve workplace cohesiveness.

The context of health care delivery was identified as an important consideration. Placing IQRNs into unfamiliar environments was recognized as a constraint to effective integration. Studies identified IQRNs need added time to transition and adjust to new or unfamiliar work environments (Wellard & Stockhausen, 2010). Reports suggest it can take up to 2 years for IQRNs "to get on their feet and be useful to the organisation" (Francis et al., 2008, p. 167). Jeon and Chenoweth (2007) also found internationally qualified nurses require additional time to acculturate to unfamiliar work environments and transition to the health care team, and found adjustment related to language and nursing practice can take several years.

While organizations value the increased diversity IQRNs bring to workplaces (Brunero et al., 2008), increased cost related to recruitment and the transition period were identified as a constraint. Studies revealed added costs were incurred by organizations in rural environments. These added costs included providing subsidized housing to attract staff and increased supernumerary hours for IQRNs during orien- tation (Francis et al., 2008). Hidden costs arose in rural areas when IQRNs employed full-time on temporary skilled work visas either reduced their hours to part-time or left to work in regional or metropolitan areas once the visa period is com- pleted (Francis et al., 2008).

Overall, IQRNs report feeling well supported when com- munities were welcoming and accepting of cultural diversity as it related to themselves and/or their families. This experi- ence was particularly evident in rural communities (Francis et al., 2008; Wellard & Stockhausen, 2010). The acceptance of cultural diversity within communities highlights the importance of sociocultural connection during IQRNs' tran- sition period (Dywili et al., 2012; Smith et al., 2011). Integration of new staff is evaluated as successful when job satisfaction increases, positive work environments are sus- tained and staff retention improves (Dywili et al., 2012).

Theme 2: Practicing Within Local Contexts

Conflicting expectations around scope of practice (SoP) dominate the literature, with numerous studies confirming IQRNs expectations of nursing practice were different to the reality of clinical practice in the AHCS (Brunero et al., 2008; Francis et al., 2008; Gillespie et al., 2012; Jeon & Chenoweth, 2007; Kawi & Xu, 2009; Smith et al., 2011; Zhou et al., 2010). Health care institutions expected IQRNs have the clinical competency to provide safe, appropriate, culturally sensitive nursing care (Dywili et al., 2012; Jeon & Chenoweth, 2007). IQRNs expectations include recognition of their skills and previous experiences, appropriate organizational orien- tation, and ongoing peer support (Dywili et al., 2012). However, studies found IQRNs previous experience was not always recognized or acknowledged meaning IQRNs had to adjust their usual SoP to work in their new environment (Smith et al., 2011). For example, IQRNs were unable to practice their standard nursing skills such as cannulation until they completed a competency assessment (Brunero et al., 2008). Conversely, a growing body of literature identi- fies that nurses from some East Asian countries are unwilling or confronted by the expectation that they will need to incor- porate holistic nursing care into their clinical practice (Francis et al., 2008; Smith et al., 2011). These nurses were unaccustomed to completing patient hygiene measures or feeding patients as, in their home country, the patient's fam- ily carry out these tasks. These nurses regarded undertaking these tasks was a belittlement of their professional status as an RN (Smith et al., 2011).

Australia's model of person-centered practice also pro- vided a challenge for many IQRNs (Kawi & Xu, 2009). Collaborative and respectful communication with patients is central to this model of care. The importance of recogniz- ing the cultural differences in therapeutic communication was illustrated in several studies (O'Neill, 2011; Zhou et al., 2011). Hierarchical structures exist in health care sys- tems and are perceived differently in different cultures (Kishi et al., 2014). RNs from China, Japan, or India are accustomed to patients accepting the doctor or senior nurse's instructions without question. Yet in Australia, ther- apeutic communication is more collective with health pro- fessionals and patients collaborating in decision making (Smith et al., 2011).

English language proficiency, understanding Australian colloquialisms, pronunciation, or accents also proved chal- lenging for IQRNs (Jeon & Chenoweth, 2007; O'Neill, 2011). Nonverbal communication was also observed by Kawi and Xu (2009) as causing potential misunderstandings between health professionals and patients. Several studies acknowledged IQRNs experienced additional challenges learning variations in drug names, and in

understanding the meaning ascribed to abbreviations in medical and nursing staff communications (Jeon & Chenoweth, 2007; Takeno, 2010). This was also true for native English-speaking nurses (Zhou et al., 2011), which means this is likely reflective of all RNs preparation for this component of practice.

The literature (Kishi et al., 2014; Timilsina Bhandari et al., 2015) recognized that a positive work environment is predictive of improved retention of both international and local nurses. These findings also argue that health care delivery is shaped and influenced by the context or setting in which it occurs (Smith et al., 2011). While it is widely recog- nized that English language proficiency and interpersonal relationships are important, positive, and supportive work practice environments influence job satisfaction (Kishi et al., 2014; Timilsina Bhandari et al., 2015). Using narratives of IQRNs' experience to increase understanding of the dominant workplace culture was found to be a useful approach to improve cohesion (Brunero et al., 2008). Other results identi- fied that positive group integration between local and international nurses occurred during informal conversations in relaxed or casual settings (Xiao et al., 2014). Conversely, one study found the local staff was excluded by language and reverse cultural barriers when IQRNs formed subgroups (Xiao et al., 2014).

Studies revealed not all IQRNs had positive experiences transitioning into the health workforce. Inadequate resources, insufficient support or educational information, nonrecognition of skills, knowledge or experience, inequity of opportu- nity for career advancement, and cultural barriers were identified by IQRNs as constraints to integrating into the AHCS (Dywili et al., 2012; Francis et al., 2008; Jeon & Chenoweth, 2007; Kawi & Xu, 2009; Xiao et al., 2014). Studies also identified IQRNs experienced incongruence between the expectations of the job and the actual demands of the job (Smith et al., 2011) that were compounded by the different values they held resulting in challenges during the transition period. However, Timilsina Bhandari et al. (2015) study found that developing respectful interprofessional rela- tionships with staff, colleagues, and community, in addition to remuneration and being able to communicate proficiently in English, were positively associated with job satisfaction.

Theme 3: Experiencing Prejudice

Racial prejudice expressed in nurse-to-nurse racism, and patient-to-nurse racism occurred within organizations and communities (Mapedzahama et al., 2012; Timilsina Bhandari et al.,

2015; Zhou et al., 2011). Yet contemporary racism can manifest itself in subtle forms. For example, experiences of racism and discrimination were inscribed in IQRNs' descrip- tions of experiencing increased feelings of homesickness, feelings of exclusion, or marginalization. Several studies cite when language and culture are used to classify difference, this can result in stereotyping cultural behaviors (Kawi & Xu, 2009; Mapedzahama et al., 2012; Zhou et al., 2011). Stigma also occurs when negative meanings are ascribed to difference, which can perpetuate racism (Zhou et al., 2011). IQRN's experience of discrimination was acknowl- edged in several studies (Takeno, 2010; Timilsina Bhandari et al., 2015; Xiao et al., 2014). These authors' referred to the non-recognition of overseas qualifications, skills, knowledge, or experience as discriminatory (Smith et al., 2011; Timilsina Bhandari et al., 2015). Reports of IQRNs being denied the opportunity to practice in their area of expertise were also identified (Brunero et al., 2008) as discriminatory. Being labelled as incompetent or needs surveillance was similarly seen by IQRNs as dis- criminatory. Career advancement or promotion opportuni- ties for NESB nurses were discussed as compromised, limited, or denied (Kawi & Xu, 2009; Timilsina Bhandari et al., 2015). However, when too much assistance was proffered IQRNs also perceived this as a form of covert discrimination (Takeno, 2010). Therefore, organizations and nurse leaders need to comprehend the complexity and social dynamism of workplaces and how this affects an IQRNs transition to working in the AHCS. Being sensi- tive to the social dynamics of workplaces can provide insight into potential incidences requiring intervention (Mapedzahama et al., 2012).

Several studies identified that nurse managers also require organizational support to manage issues and complaints sur- rounding racism, discrimination, or prejudicial behavior (Timilsina Bhandari et al., 2015; Xiao et al., 2014). Issues raised by nurses need to be acknowledged and addressed by managers to avoid passive racism which occurs when leaders remain silent or do not act to address incidents of discrimina- tion (Mapedzahama et al., 2012). Studies identified manage- ment need resources to implement and action anti-racism and anti-discrimination policies, and to advocate for zero tolerance. These studies suggest additional resources such as cultural awareness programs will support nurse managers to address prejudicial behavior in workplace interactions (Smith et al., 2011; Xiao et al., 2014).

Discussion

The reviewed literature identified that orientation programs and supportive strategies are vital in facilitating an individ- ual nurse's successful transition to a foreign health service.

However, the efficacy of the existing orientation programs designed to assist transition is yet to be determined in terms of impact (Covell, Neiterman, & Bourgeault, 2016). Much of the discussion in the literature has centered on the need to provide timely and ongoing support during transition, while the most successful programs have emphasized meeting an individual's needs and level of cultural awareness (Kehoe et al., 2016). Therefore, transition programs should be tai- lored to meet specific needs and incorporate cultural aware- ness at both the organizational and the individual level. Programs and policy aimed at improving the cultural respon- siveness capabilities of nurses and healthcare organizations can improve outcomes for patients and communities while improving IQRNs adeptness to integrate successfully into the work environment.

Within the nursing profession, an understanding of the differences in educational preparation in countries of origin can reduce confusion over the SoP for IQRNs. The Nursing and Midwifery Board of Australia (2016) provide the follow- ing definition of SoP for the RN:

> Scope of practice is that in which nurses are educated, competent to perform and permitted by law. The actual scope of practice is influenced by the context in which the nurse practises, the health needs of people, the level of competence and confidence of the nurse and the policy requirements of the service provider.

This review highlights that the expectations of IQRNs often differed from the reality of clinical practice. Few interna- tional health professionals consider differences in national practices in advance of their transition into the new work- force (Harris, 2011). These findings suggest mutual dis- course needs to occur to clarify the expectations around SoP at the point of care. In addition, a shared understanding of IQRN's education and clinical experience may identify the strengths that IQRNs bring to the workplace and enable these nurses to work to their full potential.

Such understanding is particularly important when ambi- guity exists as to how differences in educational preparation affect clinical competencies and critical thinking skills. The model of person-centered practice that can prove challenging for IQRNs creates a similar quandary for other overseas- qualified health professionals. Dahm (2011) acknowledged that, while international medical graduates (IMGs) may be experts in medical knowledge, they may not be familiar with Australia's model of person-centered care (PCC), and may have difficulty adjusting their practice. Yet PCC is a key pol- icy driver for quality and safety. While the

fundamentals of PCC derived from the nursing, medical, and health policy literature are similar, various professions have focused on different areas within this model (Kitson, Marshall, Bassett, & Zeitz, 2013). Nevertheless, IQRNs and IMGs are both expected to develop a rapport with patients and communi- cate collaboratively using a person-centered model of care (McGrath, Henderson, Tamargo, & Holewa, 2012).

English language proficiency and having an effective style of therapeutic communication is required for any inter- national health professionals who does not have English as their first language. Although English language proficiency is a prerequisite for registration in Australia, both IQRNs and IMGs from NESBs may also require language support once registered (McGrath, Henderson, & Holewa, 2013). Excluding those who had studied or spoken English at home or school, IMGs from Middle Eastern countries indicate that communicating in English presented significant challenges for them in the workplace (McGrath et al., 2013). Contrary to expectations, it is not the comprehension and written lan- guage skills that present the most challenges, but communi- cating verbally in English. Nevertheless, international health professionals feel they are well understood by their peers (McGrath et al., 2013). An important issue emerging from these findings is that suboptimal communication in English can have a negative impact on patient satisfaction (Sommer, Macdonald, Bulsara, & Lim, 2012). Failure to address com- munication issues can leave both international health profes- sionals and patients vulnerable.

In addition to language issues, accents also featured in the literature (McGrath et al., 2013). Patient care outcomes can be negatively affected if there is a miscommunication because of poor clarity of English. Findings suggest miscom- munications related to accented English and/or lack of local technical terms remain a barrier to effective two-way thera- peutic communication. The finding that understanding Australian colloquialisms was an area of difficulty for IQRNs was reflective of IMGs' experiences (McGrath et al., 2013). Notwithstanding such difficulties, IMGs themselves do not consider that their accents or English language proficiency pose a barrier when interacting with patients (Sommer et al., 2012).

Cultural and linguistic diversity exist within health care professions. Much of the literature reviewed approaches lan- guage in the context that native English is the gold standard. IQRNs or IMGs from NESBs are discussed in terms of being a problem or having a deficit

that needs addressing; less emphasis is placed on the benefits bilingual or multilingual health care professionals bring to the workplace. Yet when differences in cultural and language backgrounds are embraced, opportunities to develop new perspectives and ways of thinking and to learn from each other in the process arise (Chur-Hansen & Woodward-Kron, 2009). It is in this context that cultural competence and cultural diversity edu- cation have the potential to inadvertently reinforce local staff members' stereotypes about IQRNs. Thus, the emphasis on the other can create power imbalances by inadvertently sug- gesting that a group is tolerated within a community, rather than being an intrinsic part of it. Fostering inclusive environ- ments that acknowledge and accommodate differences can facilitate successful integration of IQRNs. However, suc- cessful programs that address workforce diversity require support and engagement at the organizational, institutional, and ward levels. Yet we need to be mindful to not underesti- mate the complexity within cultural groups. To promote social inclusiveness, health professionals need to be active in providing counterpoint to the prejudices found within nurs- ing and the broader community (Kymlicka & Banting, 2006).

While Australia is a multicultural society, racial discrimi- nation, and prejudice still occurs. It is incumbent on all of us to address racism and discriminatory actions. An implication of the findings of this review is that to enable the provision of culturally congruent and appropriate PCC, nurses also must support each other while working together in the com- plex, dynamic workplaces that comprise the AHCS. Further research is needed to better understand how healthcare orga- nizations, nurse leaders and nurses themselves can continue to support equity, value cultural diversity and promote cul- tural tolerance, respect, and appreciation at every level. Future research into the development of specified cultural diversity standards, indicators, and benchmarks to test the efficacy of cultural responsiveness programs is also recom- mended. Furthermore research to evaluate the ways in which these programs affect patient care is warranted.

Conclusion

The demand for health services worldwide continues to increase at a rate beyond that expected from population growth alone. Political, economic, social, and cultural fac- tors affect nursing workforce migration and health care delivery worldwide. The findings from this review suggest that these migration patterns create a need for increased understanding of the system-level determinants of successful integration. At a local level, the values and culture of the organization affect the transition and integration experiences of international nurses into a foreign healthcare system. This is important evidence to consider in an era of

increasing global complexity; as it is vital, we do not underestimate the impact global migration has on health workforces. Cultural competency continuing professional development to improve nurses' ability to communicate effectively with colleagues and patients from different cultures is essential for the provi- sion of culturally congruent health care. Safe, sustainable, and effective provision of health care to meet the require- ments of individuals, families, and communities is the ulti- mate goal of nursing practice, regardless of the place of origin of the practitioner.

Study Limitations

The exclusion of non-English papers and the imposition of a time frame for the reasons described in this article may have resulted in other relevant material not being included. The small sample size is acknowledged; however, this is repre- sentative of the available published work. The findings reported in most studies were acknowledged as non-general- izable, mostly due to small sample size or specific contexts.

Authors' Note

YCT, MB, and JM were responsible for the study conception and design and drafting of the article. They made critical revisions to the article.

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Table 1. Stages in the Review Process Using Whittemore and Knafl (2005) Modified Integrative Review Framework.

Problem identification	Literature search	Data evaluation	Data analysis	Presentation
Area of inquiry: IQRN in AHCS The aim of integrative review is to identify and appraise research findings about the experiences of IQRNs working in the AHCS	Databases: CINAHL, MEDLINE (Ovid), and SCOPUS Key terms Limits: Dates January 1, 2007 to July 1, 2016 Inclusion/exclusion criteria	Records Method CASP tool to appraise relevance, rigor, and quality of the study and then to identify primary records for inclusion	Data extracted from primary sources and coded for key incidents. Comparative analysis of codes conducted and major themes identified.	Major themes

Note. IQRN = internationally qualified registered nurse; AHCS = Australian healthcare system; CASP = Critical Appraisal Skills Programme

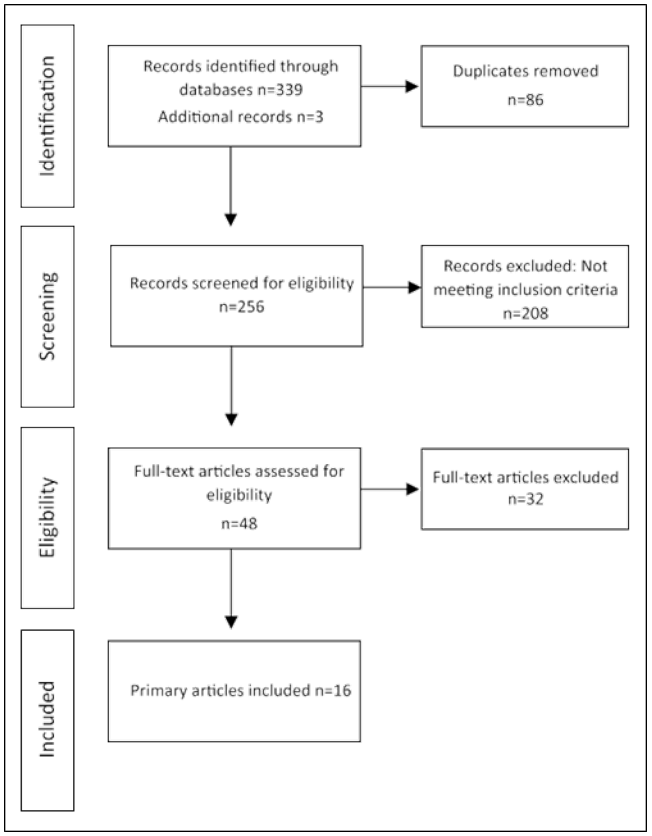

Figure 1. PRISMA flow diagram of search, screening, and selection.

Note. PRISMA = Preferred Reporting Items for Systematic reviews and Meta-Analyses.

Table 2. Inclusion and Exclusion Criteria.

Inclusion criteria	Exclusion criteria
Year range: Published between January 1, 2007 and July 1, 2016	Workshop and conference presentations
Language: Published in English	Working papers
Publication type: Peer-reviewed research articles	Literature—not peer-reviewed research
Setting: Australian healthcare system	Countries other than Australia
Population: Internationally qualified registered nurses	Pre-registration nursing students

Table 3. List of Reviewed Articles and Summary of Results.

	Author (year)	Title/journal	Aim	Methodology/method	Participants/sample/setting	Results/findings (excerpts from articles)
1	Brunero, Smith, and Bates (2008)	Expectations and experiences of recently recruited overseas-qualified nurses (OQNs) in Australia/*Contemporary Nurse*	This study examines the experiences and needs of a group of OQNs at a major metropolitan tertiary referral hospital in Australia	Descriptive survey	*n* = 56 OQNs at a major metropolitan tertiary referral hospital in Australia.	Nurses reported their experiences with three major themes emerging, career and lifestyle opportunities, differences in practice and homesickness.
2	Dywili, Bonner, Anderson, and O' Brien (2012)	Experience of overseas-trained health professionals in rural and remote areas of destination countries: A literature review/*Australian Journal of Rural Health*	This study aimed to review and synthesize existing literature that investigated the experience of overseas-trained health professionals (OTHPs) in rural and remote areas of destination countries.	A systematic literature review using electronic databases and manual search of studies published January 2004 to February 2011. Data were analyzed from articles that met inclusion criteria.	*n* = 17 Articles. The reviewed research studies were conducted in Australia, Canada, New Zealand, the United Kingdom, and the United States. Overseas-trained medical practitioners were the most frequently researched (*n* = 14); two studies involved nurses and one study included several health professionals.	Three main themes emerged from the review and these were the following: (a) expectations, (b) cultural diversity, and (c) orientation and integration to rural and remote health work environment.
3	Francis, Chapman, Doolan, Sellick, and Barnett (2008)	Using overseas registered nurses (RNs) to fill employment gaps in rural health services: Quick fix or sustainable strategy?/*Australian Journal of Rural Health*	Objective: This study sought to identify and evaluate approaches used to attract internationally trained nurses from traditional and nontraditional countries and incentives employed to retain them in small rural hospitals in Gippsland, Victoria.	Design: An exploratory descriptive design.	Setting: Small rural hospitals in Gippsland, Victoria. Participants: Hospital staff responsible for recruitment of nurses and overseas-trained nurses (OTNs) from traditional and nontraditional sources (e.g., England, Scotland, India, Zimbabwe, Holland, Singapore, Malaysia).	Recruitment of married OTNs is more sustainable than that of single RNs; however, the process of recruitment for the hospital and potential employees is costly. Rural hospitality diffuses some of these expenses by the employing hospitals providing emergency accommodation and necessary furnishings. Cultural differences and dissonance regarding practice create barriers for some of the OTNs.
4	Gillespie, Chaboyer, Lingard, and Ball (2012)	Perioperative nurses' perceptions of competence: Implications for migration/*ACORN: Journal of Perioperative Nursing in Australia*	This article describes Canadian and Australian nurses' levels of perceived perioperative competence and discusses these results in the context of nurse migration.	Perioperative competence was measured with a 40-item self-report survey. Nonparametric tests were used to describe differences between groups based on country of origin, years of experience and qualifications.	Nurses in six hospital sites (three in Canada and three in Australia).	Canadian and Australian nurses reported their overall competency levels as high across all domains. Significant differences were found, between countries, in three of the six competency domains; foundational knowledge and skills ($p < .001$), collegiality ($p = .023$), and empathy ($p < .0001$). The increasing global mobility of nurses makes it imperative to further standardize with an international perspective, knowledge, and practice expectations in perioperative settings.
5	Jeon and Chenoweth (2007)	Working with a culturally and linguistically diverse (CALD) group of nurses/*Collegian*	To provide a critical examination of the issues and challenges relating to the employment of OQNs within Australia and international contexts.	Data analysis	OQNs in Australia.	New OQNs experience difficulties with language, communication styles, unfamiliar nursing practice, and work environment as well as cultural difference. Require support to acculturate to unfamiliar work conditions, and make a smooth transition to the health team. Australian trained nurses also need to be supported in terms of being given opportunities to develop cultural competence and to learn how to work collaboratively within the CALD work setting.

(continued)

Table 3. (continued)

	Author (year)	Title/journal	Aim	Methodology/method	Participants/sample/setting	Results/findings (excerpts from articles)
6	Kawi and Xu (2009)	Facilitators and barriers to adjustment of international nurses: An integrative review/*International Nursing Review*	Aim: This integrative review identifies facilitators and barriers encountered by INs as they adjust to foreign health care environments.	Method: Based on Cooper's Five Stages of Integrative Research Review, a systematic search of eight electronic databases was conducted, combined with hand and ancestral searches.	Findings: Twenty-nine studies conducted in Australia, Canada, Iceland, the United Kingdom, and the United States were included in this review. Subsequently, facilitators and barriers were identified and categorized into themes and subthemes	Findings indicated that positive work ethic, persistence, psychosocial, and logistical support, learning to be assertive and continuous learning facilitated the adjustment of INs to their new workplace environments. In contrast, language and communication difficulties, differences in culture-based lifeways, lack of support, inadequate orientation, differences in nursing practice, and inequality were barriers.
7	Kishi, Inoue, Crookes, and Shorten (2014)	A Model of adaptation of overseas nurses: Exploring the experiences of Japanese nurses working in Australia/*Journal of Transcultural Nursing*	The purpose of the study was to investigate the experiences of Japanese nurses and their adaptation to their work environment in Australia.	Qualitative research method, individual semistructured interviews, thematic analysis used to identify themes within the data.	*n* = 14 Japanese RNs working in Australian hospitals	The conceptual model of the adaptation processes of 14 Japanese nurses working in Australia includes the seeking, acclimatizing, and settling phases. Although these phases are not mutually exclusive and the process is not necessarily uniformly linear, all participants in this study passed through this S. A. S. model to adapt to their new environment.
8	Mapedzahama, Rudge, West, and Perron (2012)	Black nurse in white space? Rethinking the in/visibility of race within the Australian nursing workplace/*Nursing Inquiry*	This article presents an analysis of data from a critical qualitative study with 14 skilled Black African migrant nurses experiences of racism and racial prejudice in Australian nursing workplaces.	Essed's framework of "everyday racism" to theorize narratives	*n* = 14 Black African migrant nurses working in Australian nursing workplaces	Racism generally and nurse-to-nurse racism specifically, continues to be underresearched in explorations of these workplaces; when racism is researched, the focus is nurse-to-patient racism and racial prejudice.
9	O'Neill (2011)	From language classroom to clinical context: The role of language and culture in communication for nurses using English as a second language: A thematic analysis/*International Journal of Nursing Studies*	Explores the experiences of internationally educated nurses using English as a second language, recruited by advanced economies to supplement diminishing local workforces, as they progress from language learning programs to clinical settings	Semistructured interviews, nurses' narratives, thematic analysis	*n* = 10 Internationally educated nurses. Participants: Six female participants and four male. Five participants were Indian, four Chinese, and one Nepalese.	Themes of identity and belonging, safety and competence and adapting to new roles and ways of communicating are revealed. In their own words, these nurses reveal the challenges they face as they concurrently manage the roles of language learners and professionals.
10	Smith, Fisher, and Mercer (2011)	Rediscovering nursing: A study of overseas nurses working in Western Australia/*Nursing & Health Sciences*	This article presents the findings of a study, based on Husserlian phenomenology that describes the work experience of 13 female nurses who were working in Western Australia, Australia.	Husserlian phenomenology	*n* = 13 Female nurses who were working in Western Australia	The participants were taken aback by the way that nursing is practiced in Western Australia. The major differences that they encountered were related to clinical skills, holistic care, the work dynamic with doctors and patients, and the overall societal status of the nursing profession. As a result, they had to adjust their practice to conform to the new work environment.
11	Takeno (2010)	Facilitating the transition of Asian nurses to work in Australia/*Journal of Nursing Management*	The purpose of the present study was to explore the perceptions of Korean and Japanese nurses' about nursing in Australia	Qualitative research methodology comprised in-depth semistructured interviews	Five RNs, who had worked in both Australia and their home country of Korea or Japan	Research participants were mostly satisfied with working conditions, support, and continuing nursing education in Australia. English language deficits, differences in culture and beliefs about the nurse's role were found that could create the potential for misunderstandings. Recognized too much help may be a form of covert discrimination.

(continued)

Table 3. (continued)

	Author (year)	Title/journal	Aim	Methodology/method	Participants/sample/setting	Results/findings (excerpts from articles)
12	Timilsina Bhandari, Xiao, and Belan (2015)	Job satisfaction of overseas-qualified nurses working in Australian hospitals/*International Nursing Review*	To explore factors associated with the job satisfaction of OQNs working in South Australia. Compare satisfaction between English-speaking and non-English-speaking background (NESB) OQNs	A cross-sectional survey using the job satisfaction of OQNs questionnaire	*n* = 151 OQNs from 24 countries recruited from five SA hospitals	Four factors influence job satisfaction: Supportive work environment, interpersonal relationships, communication in English, and salary and salary-related benefits. Communication most associated with job satisfaction in nurses from NESB. NESB nurses require support early in their employment, especially with their communication skills. Open-ended questions revealed discrimination and racism issues.
13	Wellard and Stockhausen (2010)	Overseas trained nurses working in regional and rural practice settings: Do we understand the issues?/*Rural and Remote Health*	This review explored the contemporary understandings of the employment of OTNs in Australian regional and rural practice settings.	An integrative literature review was undertaken. A search of electronic databases and relevant web pages was undertaken for the publication period 1995 to 2008.	Following identification of relevant literature, thematic analysis was undertaken to reveal patterns and relationships among concepts facilitating synthesis of findings across the range of literature	This review identified a number of economic and ethical issues, together with risks for potential exploitation of migrant nurses. There was minimal literature specific to the experiences of OTNs working in regional and rural areas. The employment of OTNs is accompanied by complex and varied issues which require resourceful and proactive responses by health care employers. Increased understanding in clinical settings of factors that influence nurses to migrate, as well as the range of barriers they face in working and living in host countries, may assist in the retention of these nurses.
14	Xiao, Willis, and Jeffers (2014)	Factors affecting the integration of immigrant nurses into the nursing workforce: A double hermeneutic study/*International Journal of Nursing Studies*	The aim of this study was to examine interplaying relationships between social structures and nurses' actions that either enabled or inhibited workforce integration in hospital settings.	Giddens' Structuration Theory with double hermeneutic methodology. Face-to-face in-depth interviews and focus groups.	*n* = 24 Immigrant and *n* = 20 senior Australian nurses working in an Australian metropolitan city hospital setting	Four themes identified: (a) employer-sponsored visa as a constraint on adaptation (b) two-way learning and adaptation in multicultural teams (c) unacknowledged experiences and expertise as barriers to integration (d) unquestioned subgroup norms as barriers for group cohesion.
15	Zhou, Windsor, Coyer, and Theobald (2010)	Ambivalence and the experience of China-educated nurses working in Australia/*Nursing Inquiry*	Based on our study findings on the experience of China-educated nurses working in Australia, this study proposes that the concept of ambivalence is more appropriate in portraying the experience of immigrant nurses.	Modified constructivist grounded theory. Symbolic Interactionist approach. In-depth interviews.	*n* = 28 Purposive sample of China educated nurses working >6 months as RN in AHCS in Brisbane and Adelaide	Conflicting social and cultural norm, immigration ambivalence; discrepancies between expectation and reality, Perceptions include dual-reference points of comparison, and divergent interests within families.
16	Zhou, Windsor, Theobald, and Coyer (2011)	The concept of difference and the experience of China-educated nurses working in Australia: A symbolic interactionist exploration/*International Journal of Nursing Studies*	In reporting on an analysis of data drawn from China-educated nurses working in the Australian health care system, this article explores the social construction of difference and the related intersection of difference and racialization.	Symbolic interactionist approach informed in-depth interviews. Analysis was initial and focused coding and constant comparison of data.	*n* = 28 China educated nurses employed as RNs in Australia.	Two levels of meaning were depicted in this study: difference as "you are you and I am I" and difference as "incompetence." Negative meanings were ascribed to difference which in turn legitimized inequality and held the potential to perpetuate racism.