Intra-Professional Cultural Competence: Exploring a Strategy to Support Internationally Qualified Nurses and Australia's Culturally and Linguistically Diverse Nursing Workforce

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Abstract

This four-part thesis examined the experiences of internationally qualified nurses (IQNs) and culturally and linguistically diverse (CALD) nurses in Australia through exploratory descriptive research. It aimed to determine the barriers and facilitators to the professional integration of IQNs in Australia; identify the cultural and linguistic characteristics of the Australian nursing workforce; ascertain how regulators address the barriers and facilitators to IQN integration; explore how educational and regulatory experts view the elements of Intra-professional Cultural Competence (IPCC) in Australia; and analyse the experiences of the elements of IPCC in one nursing school in relation to education and clinical practice.

Four studies were undertaken: Study One - a systematic review - identified significant challenges to IQN professional integration. Study Two - a workforce data analysis - identified that when IQNs and overseas-born locally qualified nurses are included, CALD nurses may represent 43% of the Australian nursing workforce. Study Two developed the concept of IPCC to explore the intra-professional applicability of cultural competence. IPCC was defined by four elements: mutual collaboration and professional relationships; prevention of racism and discrimination (R&D) and bullying and harassment (B&H); respecting the values, attitudes and beliefs of individuals from different cultures; and responding appropriately to cross-cultural interactions with colleagues. These elements of the concept were further examined in Studies Three and Four.

Study Three - an examination of nursing regulatory documents - demonstrated the presence of IPCC elements in these documents to support IQN integration. Study Four - the interviews with educational and regulatory experts, academics and clinical educators - confirmed that, while IPCC elements were recognised in both regulatory documents and educational practices, R&D and B&H also coexist. The thesis concludes with a discussion of recommendations relevant to the integration of IPCC by regulatory bodies, educational providers and healthcare organisations, and of implications for future research.

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I would like to begin by expressing my profound gratitude for having reached the completion of this PhD. This has been a challenging and transformative journey, both personally and intellectually. There were moments when the road seemed too difficult, but each experience - both positive and trying - has shaped me into a person who now sees the world through new eyes.

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Statement of originality

This is to certify that, to the best of my knowledge, the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes.

I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.

This research reported in this thesis was supported by the award of a Research Training Program scholarship to the PhD Candidate.

Signature:

Date: December 30 2024.

Supervisors' statement

As supervisor of Marcela Correa-Betancour's doctoral work, I certify that I consider this thesis "Intra-professional cultural competence: Exploring a strategy to support internationally qualified nurses and Australia's culturally and linguistically diverse nursing workforce" to be suitable for examination.

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Authorship attribution statement

Chapter Three of this thesis includes two publications as follows:

Correa-Betancour, M., Marcus, K., Balasubramanian, M., & Short, S. D. (2022, August 9). *Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: A mixed methods systematic review protocol*. OSF Registries. https://doi.org/10.17605/OSF.IO/WMSH3

> In this protocol, I conceptualised and designed the study following the Joanna Briggs Institute mixed methods systematic review protocol. I conducted the literature search, authored and reviewed the manuscript, and facilitated approval of the final version for publication.

Correa-Betancour, M., Marcus, K., Balasubramanian, M., & Short, S. D. (2024). Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: A mixed methods systematic review. *Australian Journal of Advanced Nursing*, *41*(1), 39–53. https://doi.org/10.37464/2024.411.933

> In this study, I conceptualised and designed the research, conducted the literature search and data collection, analysed and interpreted the data, performed the critical appraisal of the selected studies, drafted the final version for submission, responded to peer reviewers, and facilitated approval of the final version for publication. The co-authors served as second reviewers and provided feedback and oversight throughout each stage of the process.

Chapter Four of this thesis includes an article which is currently under review with a journal; submitted 3 October 2024:

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> In this study, I conceptualised and designed the research, conducted the literature search and data collection from databases, analysed and interpreted the data, drafted

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Abbreviations

Ahpra	Australian Health Practitioner Regulation Agency
ANMAC	Australian Nursing and Midwifery Accreditation Council
B&H	Bullying and harassment
BN	Bachelor of Nursing
CALD	Culturally and linguistically diverse
CE	Clinical educator
IQN	Internationally Qualified Nurse
IPCC	Intra-professional cultural competence
JBI	Joanna Briggs Institute
LQN	Locally qualified nurse
NMBA	Nursing and Midwifery Board of Australia
NUM	Nurse manager
OECD	Organisation for Economic Co-operation and Development
R&D	Racism and discrimination
RN	Registered nurse
UK	United Kingdom
USA	United States
VAD	Voluntary assisted dying

Chapter One

Introduction

This chapter will provide an overview of the background required to understand the significance of this research. First, this chapter will provide a brief description of **nursing in Australia**, tracing its origins back to 1838. Next, it will cover **nursing education** and some of the **regulatory documents** governing nursing practice, including the Nursing and Midwifery Board of Australia Code of Conduct, the registered nurse (RN) Standards for Practice and the Australian Nursing and Midwifery Accreditation Council Accreditation standards. Then it will present an analysis of the **nursing workforce** in Australia, and the ongoing **National Nursing Workforce Strategy** and its preliminary findings.

The next theme will briefly explore the origins of **nurse migration**, with a focus on the Australian experience. It will discuss the current state of nurse migration in the global context, and the significance of **internationally qualified nurses** (IQNs) in Australia, concluding with an examination of the registration process for IQNs in Australia.

Following this, the definition of **acculturation** will be provided, highlighting its importance in nursing practice. Definitions will be provided for **racism, discrimination, bullying and harassment**, followed by a brief description of how these behaviours impact the ability of nurses to provide quality care. Then the definition of and rationale for the use of **cultural competence** and development of concept of **intra-professional cultural competence** will be provided.

The **research gaps** and rationale will be clearly outlined, along with the specific **aims** and **objectives** of the research, followed by an explanation of the **structure and content** of the thesis chapters. Finally, I shall briefly explain my **personal journey** and how this may incur a risk of bias, and the strategies employed to address that risk.

1.1 Nursing in Australia

The history of nursing in Australia is inherently intertwined with that of Great Britain. The first hospital-trained nurses arrived in Australia in 1838, with a small group of Sisters of Charity. Among them, two had received nursing training and experience in France and Ireland. They disembarked in Sydney and eventually established themselves at St Vincent's Hospital in the city (Burrows, 2018).

Before Florence Nightingale's pioneering work, nursing was not a formal profession. It was often performed by untrained individuals, including family members or members of religious orders, in informal settings such as homes or religious institutions (Dingwall et al., 1988; Tooley & Southall, 1906). The quality of care varied widely, and there were few standards governing nursing practice. Nursing was not considered a respected or professional occupation, and there was little recognition of the need for formal education or training for nurses (Helmstadter & Godden, 2016b). Nursing duties in hospitals were often performed by volunteers. However, these volunteers typically lacked the medical knowledge and skills needed to provide effective care, leading to high mortality rates among patients (Helmstadter & Godden, 2016a).

The advent of modern nursing in Australia was in 1868 when Lucy Osburn and five other formally trained nurses arrived (Burrows, 2018). This was in response to a direct request from the former New South Wales Chief Justice who asked Florence Nightingale to send trained nurses to Australia. New South Wales had supported the Nightingale funds, prompting Florence Nightingale to express her gratitude: "I would fain repay my heavy debt to Australia according to my powers" (Burrows, 2018, p. 32).

Osburn and her team were welcomed with cheers, but were shocked by the deplorable conditions they found. The infirmary had open sewer drains, no running water, cockroach-infested bandages, and reports of large black rats disturbing patients and invading the mortuary (Burrows, 2018). Despite the conditions, Osburn and her team provided exceptional care. However, Osburn faced resistance from the Infirmary's Board and surgeons. Nevertheless, within seven months, Osburn established a nurse training school based on the Nightingale model, producing sixteen trained nurses and replacing unruly staff with qualified

personnel (Burrows, 2018). She advocated for cleanliness, ventilation, nutritious food and competent care. In 1884, Osburn returned to England where she died in 1891 (Australian Dictionary of Biography, 1974).

1.1.1 Nurse education

In Australia, as in many other countries, nursing education initially followed an apprenticeship model and was conducted within hospitals (Wilson et al., 2021). This began to change significantly due to major political and social shifts. Key factors influencing this transformation included the end of World War II in 1945, the adoption of the Universal Declaration of Human Rights in 1948, and post-war advancements in technology and pharmaceuticals, all of which contributed to rapid social and economic changes (Bryant, 2022). Additionally, the establishment of the universal health scheme, Medibank, in Australia in early 1975 provided free access to hospitals and subsidised health services (Australian Government Department of Health and Aged Care, 2024c). This shift underscored the need for a greater number of better-qualified nurses.

However, the hospital apprenticeship program had become a considerable strain on the healthcare system. Moreover, successful tertiary nursing programs were already established at the University of Edinburgh (1956) and in New Zealand (1967) (Lowe, 2020).

The transition to tertiary education for nurses commenced in 1973 and was officially established in 1978 (Wilson et al., 2021). During this period, the need for nurses to perform as highly skilled healthcare professionals became evident, necessitating enhanced training (Lowe, 2020). Eventually, the shift towards tertiary education gained broader acceptance. This transition was completed in 1993 when all registered nursing students began entering the profession through tertiary education providers (Lowe, 2020). Now, Australian RNs are required to complete an accredited three-year bachelor's degree or a postgraduate degree in nursing. The accreditation is carried out by the Australian Nursing and Midwifery Accreditation Council on behalf of the Nursing and Midwifery Board of Australia. The current nursing regulatory documents are explained in the following section.

1.1.2 Nursing regulatory documents

In Australia, fifteen health professions, including nursing and midwifery, are regulated through the National Registration and Accreditation Scheme (Staunton & Chiarella, 2024). The Australian Health Practitioner Regulation Agency (Ahpra) works in partnership with 15 national boards, including the Nursing and Midwifery Board of Australia (NMBA). NMBA is an independent authority that regulates nursing registration, develops professional standards, codes and guidelines for practice, and approves accreditation standards and courses of study. Additionally, NMBA assesses IQNs who wish to be registered and practise in Australia (Australian Government Department of Health and Aged Care, 2023a). The aim of registration is to ensure that health practitioners are suitably trained, qualified and safe to practise. There is a national register of nurses in Australia, which includes any condition or restrictions on a nurse's professional practice (NMBA, 2021). The Australian Nursing and Midwifery Accreditation Council (ANMAC) functions as the external accreditation body for the NMBA, providing these services under an agreement with Ahpra (ANMAC, 2024).

1.1.3 NMBA Standards for Practice, Code of Conduct and ANMAC Accreditation Standards

The NMBA oversees nursing and midwifery practice in Australia, primarily aiming to safeguard the public. It achieves this by formulating registration standards, professional codes, guidelines and practice standards, which collectively define the criteria for professional and safe practice for nurses and midwives in Australia.

NMBA Standards for Practice

The Standards for Practice provide a general framework for evaluating RN practice. The NMBA Standards for Practice aim to inform the public about the expected standards of RNs, determine the eligibility for registration of individuals who have completed an RN program in Australia or overseas, assess RNs wishing to return to work after a period out of the workforce, and evaluate RNs who need to demonstrate their competence to practise. The RN Standards for Practice include seven interconnected standards, all based on person-centred care and evidence-based practice, and applicable to all RNs in every practice area. Each standard comes with criteria that should be interpreted within the context of practice, detailing how the standard is to be demonstrated (NMBA, 2016).

NMBA Code of Conduct

The NMBA Code of Conduct for nurses (NMBA, 2022a) sets out the legal requirements, professional behaviour and conduct expectations for nurses in all practice settings in Australia. It specifies the principles of professional behaviour necessary for safe practice, and clearly defines the expected conduct of nurses within their professional community and society at large. The Code of Conduct includes seven principles of conduct, organised into four domains, and is applicable to all forms of nursing practice, both clinical and non-clinical, paid or unpaid. Furthermore, the Code of Conduct outlines the consequences for nurses of failing to follow these principles, including registration issues and their behaviour being deemed as unsatisfactory professional performance, unprofessional conduct or professional misconduct (NMBA, 2022a).

The Health Practitioner Regulation National Law Act 2009 (Qld) recognises nursing and midwifery as distinct professions. Nursing then has three divisions: enrolled nurses, registered nurses (RNs) and nurse practitioners. Each of these titles entails different educational requirements, knowledge, skills, clinical experience and practice standards, as well as distinct responsibilities and duties. The foundational education of RNs, ENs and NPs in Australia covers the comprehensive scope of the profession at the entry level. However, the specific scope of practice for each practitioner is influenced by different factors. These include the health needs of patients, the nurse's level of competence and confidence, and the policies of their employer. The scope of practice of the nurse evolves as they learn new skills and acquire greater knowledge and skills in the field of work (NMBA, 2024b).

ANMAC Accreditation Standards

ANMAC serves as the accreditation authority for accrediting education providers and nursing programs. For an educational program to train nurses, it must receive accreditation from ANMAC and approval from the NMBA. ANMAC employs accreditation standards to evaluate and endorse these programs, ensuring they meet the criteria necessary for nursing graduates to apply for registration with the NMBA (ANMAC, 2019). These standards are integral to the National Registration and Accreditation Scheme for health practitioners, established under the *Health Practitioner Regulation National Law Act 2009* (Qld) (ANMAC, 2019).

Some accreditation requirements are relevant to this study. For example, before offering enrolment, education providers must require the applicants to demonstrate English language proficiency. Those students whose primary language is not English must provide evidence that they have met the minimum English language test scores as outlined in the NMBA's English language skills registration standard.

The program of study must be delivered at Australian Qualifications Framework Level 7 or higher, resulting in at least a bachelor's degree. It must include a minimum of 800 hours of professional experience placement for all students, completed in various settings relevant to the curriculum. Finally, the program's curriculum and learning outcomes must ensure that students achieve the NMBA RN Standards for Practice and embed principles of diversity, culture, inclusion and cultural safety for all people.

1.1.4 Profile of the Australian nursing workforce

Australia is one of the few countries that has managed to increase the total number of nurses since 2010 (Organisation for Economic Co-operation and Development [OECD], 2023). There were 10.2 nurses per 1000 population in 2010, increasing to 12.8 nurses per 1000 population in 2021; this number is higher than the OECD average of 9.2 nurses per 1000 population (OECD, 2023). This increase can be explained by the increase in nursing graduates, which is the highest among OECD countries (115.7 per 100,000 population), positioning Australia as one of the countries with an above average number of nursing graduates per capita in 2021 (OECD, 2023). Despite this effort, there is still a gap in the nursing workforce (Australian Government Department of Health and Aged Care, 2024b)

There were 368,155 RNs in Australia in 2022. The great majority (78%) of the nursing workforce qualified in Australia (locally qualified nurses), and 22% are IQNs (Australian Government Department of Health and Aged Care, 2023b). Also, 57% of the total nursing workforce was born in Australia, while 43% were born overseas (comprising IQNs and overseas-born locally qualified nurses). Only 1% of RNs in 2022 identified themselves as Aboriginal and/or Torres Strait Islander. This percentage is low and does not reflect the percentage of the Australian population that is Aboriginal and/or Torres Strait Islander, which is 3.8% (Australian Government Department of Health and Aged Care, 2023b).

In terms of gender, nursing in Australia is still a predominantly female occupation. The percentage of male nurses was 7.7% in 1997 and 9.5% in 2008, but it had risen to 12.4% in 2022 (Australian College of Nursing, 2021; Australian Government Department of Health and Aged Care, 2023b). Men in nursing predominantly work in mental health, critical care and emergency services, and 15.7% of nurse managers are male (Australian College of Nursing, 2021). Despite the increase in the percentage of male nurses, the overall number is still low.

Of the 368,155 RNs in 2022, 26,344 were not in the workforce (overseas, not looking for work or retired). For those active in the workforce, 309,851 were employed in nursing, with 278,381 in clinical roles and 31,470 in non-clinical roles. The average age of RNs in 2022 was 42.47, and the average weekly working hours were 34.26 (Australian Government Department of Health and Aged Care, 2023b). The main areas of employment for RNs in 2019 were aged care (11%), medical (9.7%), perioperative (9.4%), surgical (7.9%) and mental health (7%). The lowest percentage of nurses were employed in policy (0.2%), health promotion (0.4%), drugs and alcohol (0.6%), and research (0.7%) (Australian Government Department of Health and Aged Care, 2020).

In terms of geographical distribution, the great majority of nurses (74%) work in metropolitan areas, while 26% work in rural and remote areas (Australian Government Department of Health and Aged Care, 2020). Table 1.1 shows the distribution of RNs by state and territory and the distribution of the population by state and territory in 2019 (Australian Bureau of Statistics, 2020).

Table 1.1. Registered nurse distribution by state and territory, and population distribution by state and territory, 2019

	Registered nurse distribution by state and territory		Population distribution by state and territory	
	Number of registered nurses	**Percentage of registered nurses**	**Population number**	**Percentage of total population**
New South Wales	83,078	29%	8,129,000	32%
Victoria	75,754	26%	6,651,100	26%
Queensland	59,883	21%	5,130,000	20%
Western Australia	29,405	10%	2,639,100	10%
South Australia	22,530	8%	1,759,200	7%
Tasmania	7124	3%	537,000	2%
Australian Capital Territory	5119	2%	427,400	2%
Northem Territory	3895	1%	244,800	1%
Unknown	119	0.04%	N/A	N/A
Total	286,907	100%	25,522,169	100%

Source: Made by the candidate based on data from the Australian Bureau of Statistics, 2020, and Australian Government Department of Health and Aged Care, 2020.

1.1.5 National Nursing Workforce Strategy

The federal government of Australia is currently working on the National Nursing Workforce Strategy (Australian Government Department of Health and Aged Care, 2024a). Nurses constitute over 40% of the Australian health workforce, providing essential care across metropolitan, regional, rural and remote areas. However, despite significant investments in nursing, there has never been a national strategic approach to nursing policy. The National Nursing Workforce Strategy covers Registered Nurses (RNs), Enrolled Nurses (ENs), Nurse Practitioners (NPs), Assistants in Nursing (AINs) and nursing students.

The strategy aims to tackle workforce challenges and support the nursing profession in delivering person-centred, evidence-based and compassionate care across all sectors in

Australia. This strategy seeks to enable nurses to work to their full scope of practice to meet Australia's health and aged care needs. Key focus areas include:

- Workforce sustainability
- Diversity of the profession
- Workforce planning
- Data sharing
- Challenges of regional, rural and remote nursing
- Pathway from novice to expert.

The first stage of the strategy involves input from a wide range of stakeholders and national and international research. It was conducted between September 2023 and February 2024, and the first report was released in 2024. The initial report grouped the results into 13 key themes:

1. Planning for future workforce needs could be improved
2. Perceptions about what nurses do are often outdated
3. Continuing to recruit nurses is critical
4. Retaining nurses is as important as attracting new ones
5. Education and training can be improved
6. Support during clinical placements needs to be bolstered
7. Clear career progression is important for recruitment and retention
8. Nurses' roles and skills need to be optimised in line with changing community needs
9. Supporting nurse leaders is important for positive workplaces
10. Digital technologies will change the skills required of nurses
11. Nurses in rural and remote areas face added challenges
12. First Nations nurses face particular issues
13. Supporting a diverse nursing workforce is important.

The preliminary findings underscore the critical importance of retaining nurses, particularly those who are skilled and senior. This retention is strongly linked to factors such as workload and staff shortages, which contribute to high rates of burnout – 56% of nurses reported experiencing burnout at least once a month – and stress, with 23% indicating they feel stress

at work daily. Additionally, poor work–life balance, attributed to a lack of flexibility, is another significant factor driving nurses to leave the profession.

The findings also highlighted the necessity of providing better support for nurses from culturally and linguistically diverse (CALD) backgrounds, IQNs and nursing students to enhance their participation in the workforce. Issues reported by CALD nurses include language barriers, lack of cultural training, non-recognition of previous qualifications, and the prevalence of discrimination, racism and occupational violence (Australian Government Department of Health and Aged Care, 2024a). Despite 75% of CALD nurses expressing satisfaction in their current roles, significantly 28% reported experiencing racism in the workplace (Australian Government Department of Health and Aged Care, 2024a).

The National Nursing Workforce Strategy aims to provide a framework for strategic, long-term reform and ensure the continued trusted reputation of the nursing profession in Australia and internationally. The stages to follow the first report involve an implementation plan, and a monitoring and evaluation framework will be developed to track progress.

1.2 Migration of nurses

The migration of nurses is not a new phenomenon. As far as it is known, nurse migration has roots in the colonial era, particularly in the British Empire, where hospital-trained nurses were sent to colonies, like Australia, West Africa or India, to provide healthcare services and assist in the care of British colonisers (Brathwaite, 2018; Burrows, 2018; Howell, Rafferty, Wall, & Snaith, 2013; Staunton & Chiarella, 2024; Tooley & Southall, 1906).

The 1800s were marked by British colonialism, during which many regions of the world were ruled or administered by the UK. Inhabitants of the colonies established in these regions adapted to their specific settings while maintaining some of their customs. However, those who fell ill often succumbed due to the lack of adequate medical attention and skilled nursing care (Howell, Rafferty, & Snaith, 2011; Howell, Rafferty, Wall, & Snaith, 2013). In numerous remote regions, the availability of skilled nursing was limited, leading to significant suffering among British officials, settlers and their families (Howell, Rafferty, & Snaith, 2011; Tooley & Southall, 1906). To meet the pressing demand for trained nurses in the colonies, Lady Mabel

Piggott founded the Colonial Nursing Association (CNA) in 1895. The CNA's main purpose was to encourage nursing abroad by recruiting a qualified workforce and placing nurses in specific roles within the colonies (Howell, 2016; Howell, Rafferty, Wall, & Snaith, 2013; Rafferty, 2005).

With the establishment of the National Health Service (NHS) in the UK on 5 July 1948, the promise of universal healthcare was introduced. However, a significant shortage of healthcare workers made it difficult to fulfil this promise (Babikian, 2021). It was recognised that nurses constituted the largest and most important group of workers in the NHS, making the recruitment of nursing students crucial. Despite efforts, domestic recruitment in Britain fell short of expectations, necessitating the exploration of alternative solutions (Babikian, 2021). This is when the British colonies were approached. Informal connections were established between prospective nurses, colonial governments and hospitals facing workforce shortages. Consequently, by 1960, 15% of nursing students in Britain were from the British colonies and Commonwealth countries (Babikian, 2021).

This thesis specifically examines the migration of nurses to Australia; thus, the emphasis will be placed on literature pertinent to this context. The migration of nurses to Australia will be discussed in Section 1.2.2.

1.2.1 The global context of nurse migration today

The worldwide mobility of nursing professionals has become a crucial element to consider in healthcare workforce planning globally (Shaffer et al., 2022). The effect of this phenomenon differs in source and destination countries (Socha-Dietrich & Dumont, 2021). It is important to say that, usually, source countries are low- and middle-income countries like India, Poland and The Philippines, while destination countries usually are high-income countries such as Ireland, New Zealand and Switzerland (Socha-Dietrich & Dumont, 2021).

The effect of the migration of nurses from source countries has been widely discussed in the past (Castro-Palaganas et al., 2017; Lofters, 2012; Pittman et al., 2007; Shaffer et al., 2022; Socha-Dietrich & Dumont, 2021). This trend led to the World Health Organisation (WHO) Global Code of Practice on the International Recruitment of Health Personnel (WHO, 2010, which aims to set forth ethical principles and practices for the international recruitment of

health workers. It considers the rights, responsibilities and expectations of source countries, destination countries and migrating health professionals. Additionally, the Code seeks to foster and enhance global dialogue and cooperation on ethical recruitment issues, particularly focusing on the challenges faced by low- and middle-income countries. Adherence to the Code is voluntary (WHO, 2010).

The literature indicates that source countries face a reduction in their skilled workforce, resulting in broader gaps in healthcare provision (Buchan & Catton, 2023; Marcus et al., 2014; Rolle Sands et al., 2020). Conversely, destination countries view the recruitment of IQNs as a vital strategy for maintaining and improving healthcare standards. However, there is an intricate interaction of factors that shape the global distribution of nurses and its repercussions on healthcare systems worldwide (Buchan & Catton, 2023; Castro-Palaganas et al., 2017; Lofters, 2012; Marcus & Short, 2014; Pittman et al., 2007; Shaffer et al., 2022). Information about the percentage of IQNs in OECD countries in 2021 (based on nationality rather than place of qualification) can be found in Table 1.2 The systematic review and update to the literature in Chapter Three goes into professional integration of IQNs in detail.

Table 1.2. Percentage of IQNs (based on nationality) in the total nursing workforce of OECD countries, 2021

OECD country	Percentage of IQNs (based on nationality)
Ireland	46.6%
New Zealand	29.9%
Switzerland	25.6%
Australia	18.1%
United Kingdom	17.9%
Austria	13.2%
Israel	10.7%
Germany	9.6%
Canada	8.8%
OECD	8.7%

IQN = internationally qualified nurse; OECD = Organisation for Economic Co-operation and Development

Source: Made by the candidate using OECD Health Statistics 2023 data (OECD, 2023).

1.2.2 Internationally qualified nurses in Australia

Historically, Australia has been a host country for IQNs. This phenomenon is expected to increase with the greater need for higher nurse numbers. Australia has had a long-term reliance on attracting IQNs (Buchan & Catton, 2023; Shaffer et al., 2022) and it is expected that Australia will require a further 79,473 nurses by 2035 to fulfil its healthcare vacancies (Australian Government Department of Health and Aged Care, 2024b).

Australia allows nurses to migrate under a special scheme that recognises talent shortages (Joint Standing Committee on Migration, 2021). IQNs, especially those with equivalent qualifications, are able to obtain a working visa and also have pathways to permanent residency. The cultural and linguistic characteristics of the nursing workforce in Australia will be covered in Chapter 4.

1.2.3 Pathways to registration for internationally qualified nurses

To obtain registration to work as an RN in Australia, IQNs must meet specific criteria. The registration process is divided into three pathways, which are closely related to the country where the initial nursing qualification was obtained (NMBA, 2022b). These pathways are categorised into three streams:

> **Stream A:** Internationally qualified nurses and midwives (IQNMs) who possess a qualification deemed substantially equivalent to or founded on similar competencies as an approved qualification. Nurses from Canada, Hong Kong, Ireland, the UK and the USA are typically eligible for Stream A.
>
> **Stream B:** IQNMs with a qualification that is pertinent to the profession but does not reach the standard of substantial equivalence or is not based on comparable competencies to an approved qualification. Nurses from Belgium, Flanders (Walloon region), Chile, Pakistan, Papua New Guinea and Singapore may meet the criteria for Stream B.
>
> **Stream C:** IQNMs with a qualification that is neither substantially equivalent to nor relevant to an approved qualification. Nurses who earned their qualifications in countries specified in Table 1.3 are unlikely to meet the criteria for classification in Stream B.

Table 1.3. Countries where internationally qualified nurses and midwives obtained their first qualification, leading to classification in Stream C

Albania	Ghana	Philippines
Austria	Greece	Poland
Bahrain	India	Portugal
Bangladesh	Iran	Romania
Barbados	Iraq	Russia
Belgium (Walloon region)	Israel	Saudi Arabia
Bosnia	Italy	Serbia
Botswana	Japan	Slovenia
Brazil	Jordan	South Africa
Bulgaria	Kenya	South Korea
Cambodia	Lebanon	Spain
China	Lithuania	Sri Lanka
Colombia	Malaysia	Swaziland
Cyprus	Malta	Switzerland
Denmark	Namibia	Sweden
Estonia	Nepal	Taiwan
Fiji	Netherlands	Thailand
Former Yugoslav Republic of Macedonia	Nigeria	Turkey
France	Norway	Ukraine
Germany	Oman	Zambia
	Palestinian Territory, Occupied	Zimbabwe

Source: Made by the candidate using information from the Nursing and Midwifery Board of Australia website (NMBA, 2022b).

The steps required to obtain Australian registration depend on the stream assigned to the international qualification. To be considered and assessed by Ahpra, all candidates must complete a self-check and pay an initial assessment fee. As of 2024, this fee is AUD 410.

Once the qualifications are assessed, Ahpra determines the appropriate stream and the specific steps to follow. Nurses with qualifications classified under Stream A must complete Orientation Part 1 and then apply for registration with the NMBA. Orientation Part 1 consists of a set of videos covering topics about Australia, the Australian healthcare system, and its context. After each video, there are questions that need to be completed.

For nurses with qualifications in Stream B, they must also complete Orientation Part 1. In addition, they need to complete a portfolio. The portfolio requires uploading identification

and qualification documents (passport, bachelor's degree and any other relevant qualifications). Once these documents are assessed, which usually takes four to six months, these nurses must complete an outcomes-based assessment (OBA). The OBA consists of two evaluations: a theoretical exam and a practical exam.

The theoretical exam is a multiple-choice question exam called the NCLEX (National Council Licensure Examination). It is a content-based online test consisting of a varying number of questions. The exam takes five hours to complete and assesses knowledge in several areas: management of care (20%); safety and infection control (12%); health promotion and maintenance (9%); psychosocial integrity (9%); basic care and comfort (9%); pharmacological and parenteral therapies (15%); reduction of risk potential (12%); and physiological adaptation (14%). The next evaluation is an objective structured clinical examination (OSCE), which is an in-person clinical examination assessing the skills, competencies and applied knowledge of the candidate. The OSCE takes 3 to 3.5 hours to complete. Once candidates fulfil the requirements to be eligible for the OSCE, Ahpra will contact them to assign an examination date. Currently, there is only one centre in Australia for this assessment, located in Adelaide (NMBA, 2024b).

After successfully completing these steps, the candidate can apply for registration with the NMBA. Additional documents are required, such as a criminal history check, an English language skills test for candidates who studied in a non-English-speaking country, evidence of recency of practice, and proof of professional indemnity insurance arrangements. Nurses with qualifications in Stream C must upgrade their qualifications to obtain registration. This involves enrolling in a bridging program or completing a qualification that leads to registration in Australia. The bridging program is a full-time intensive course, followed by a practical component consisting of 240 hours of clinical placement.

Once the candidate successfully completes all the required assessment stages, they become eligible to apply for registration with the NMBA. Separate online application forms are available for candidates in Streams A and B. International qualifications applications are evaluated according to the same national assessment standards, regardless of where the application is submitted. The NMBA and Ahpra rely on the supporting documentation

provided in the application to accurately assess eligibility for registration. All supporting documentation must comply with specific Ahpra certification and translation guidelines.

1.3 Definition of acculturation and its implications

1.3.1 Acculturation

Acculturation is defined as "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (Berry, 2005, p. 698). Acculturation is a long-term process, necessitates mutual accommodation between both groups, and can produce changes in social structures and institutions (Berry, 2016). These mutual adaptations can occur smoothly or may lead to cultural conflict and acculturative stress during intercultural interactions. Cultural groups in contact cannot avoid acculturation, and all parties involved will experience some degree of change or evolution. As a result, the interaction will lead to successive changes in both cultures (Berry, 2005, 2016).

The process of acculturation is deeply influenced by the host society's stance on immigration and cultural diversity (Berry, 2005). Societies that respect and appreciate diversity generally experience stronger engagement among their cultural communities (Berry, 2005). These societies typically foster a more positive settlement environment, as their members are less inclined to impose cultural assimilation by enforcing changes in cultures or excluding immigrants through segregation and marginalisation. They are more likely to provide institutional social support and promote the development of multicultural communities (Berry, 2005).

It is important to recognise that, even in societies that embrace multiculturalisation, there are certain cultural, racial and religious groups that may encounter only partial acceptance (Berry, 2005). These groups may face hostility, rejection and discrimination, which can lead to poor long-term adaptation. The acculturation process varies significantly among individuals, with different approaches referred to as acculturation strategies. These strategies include both the attitudes (preferences for how one wishes to acculturate) and the behaviours that individuals display. However, these strategies are frequently shaped by dominant groups, and they do not exclusively depend on migrants (Berry, 2005, 2016).

1.3.2 Acculturation strategies

Acculturation strategies refer to the methods through which non-dominant cultural groups or individuals navigate the acculturation process. Four acculturation strategies have been described by Berry (2005, 2016):

a) **Assimilation:** This occurs when individuals choose not to preserve their cultural identity and instead seek regular interaction with other cultures. In this process, individuals prefer to abandon their heritage culture and integrate fully into the dominant society (Berry, 2005, 2016).

b) **Integration:** This occurs when individuals are interested in both preserving their original culture and engaging in daily interactions with other cultural groups. In this approach, individuals maintain a degree of cultural integrity, while also actively participating in the larger society. Achieving integration requires mutual accommodation between the cultural groups involved (Berry, 2005, 2016).

c) **Separation:** This strategy occurs when individuals prioritise retaining their original culture, while actively avoiding interactions with other cultural groups. In this case, individuals choose not to engage with the dominant cultural group (Berry, 2005, 2016).

d) **Marginalisation**: This situation occurs when individuals show little interest in maintaining their heritage culture and have minimal desire to engage with other cultural groups (Berry, 2005, 2016).

Drawing from the experience of working in multicultural teams and considering the perspective of IQNs, fostering assimilation or integration within the workforce could enhance professional integration (Pressley et al., 2022) and job satisfaction (Joensuu et al., 2024; Thomas & Lee, 2024), and improve nurse retention (Thomas & Lee, 2024).

1.4 Definitions of racism, discrimination, bullying and harassment in nursing

The literature shows that racism, discrimination, bullying and harassment are still present in nursing (Brewer et al., 2020; Gauci et al., 2022; Hartin et al., 2018; Kahsay et al., 2020; Lever

et al., 2019; Likupe, 2015; Parke et al., 2023; Pogue et al., 2022; Sauer & McCoy, 2017; Serafin et al., 2020; Tuttas, 2015; ZareKhafri et al., 2022).

Racism encompasses systems, policies, actions and attitudes that create unequal opportunities and outcomes for individuals based on race, extending beyond mere prejudice in thoughts or behaviour (Australian Human Rights Commission, n.d.-d). Racism manifests when such prejudice, whether on an individual or institutional level, is coupled with the power to discriminate against, oppress or restrict the rights of others (Australian Human Rights Commission, n.d.-d).

Since European colonisation of Australia began in 1788, race and racism have been integral to the organisation of Australian society (Australian Human Rights Commission, n.d.-d). Aboriginal and Torres Strait Islander peoples, as the First Peoples of Australia, have been profoundly affected by colonisation and experience unique forms of racism. The colonisation process and its underlying beliefs continue to influence Australian society today (Australian Human Rights Commission, n.d.-d). The *Immigration Restriction Act 1901* established the "White Australia Policy", which sought to preserve a homogeneous European population (Mence et al., 2017). Throughout the early 20th century, migration policies favoured European immigrants, particularly from Britain, to maintain Australia's predominantly white, British identity. The government officially ended the White Australia Policy in 1973 (Mence et al., 2017).

Racism evolves over time and affects different communities in various ways. At different historical moments, certain groups may experience intensified racism. Understanding this dynamic nature of racism is crucial for addressing its current and future impacts on diverse communities within Australia (Australian Human Rights Commission, n.d.-d). A national consultation published in 2024 shows that 28% of CALD nurses say they have experienced racism (Australian Government Department of Health and Aged Care, 2024a).

Discrimination occurs when an individual or group is treated unfairly compared to others due to their background or specific personal traits, a situation known as direct discrimination (Australian Human Rights Commission, n.d.-a). Additionally, discrimination occurs when an unreasonable rule or policy, though applied universally, disproportionately disadvantages

certain individuals because of a shared personal characteristic. This is referred to as indirect discrimination (Australian Human Rights Commission, n.d.-a). There are many sources of discrimination in the healthcare setting; some examples can be based on racism, ageism, gender or gender identity.

Bullying involves the repeated and deliberate use of words or actions against an individual or group to cause distress and jeopardise their wellbeing (NMBA, 2022a, p. 11). This behaviour is typically carried out by those who have greater influence or power over the victim or who seek to make the victim feel powerless or helpless (Australian Human Rights Commission, n.d.-c). Bullying can be direct, involving physical or verbal actions in face-to-face interactions, or it can be indirect and covert, making it harder to detect and address. Indirect bullying includes actions such as social exclusion or spreading false information and rumours about the victim (Australian Human Rights Commission, n.d.-c). Additionally, bullying can occur through digital means (cyberbullying), such as social media platforms, messaging apps, chats, texts, emails and other communication technologies. In these cases, bullying can be anonymous, reach a broad audience, and the harmful content can be difficult to remove once it has been shared (Australian Human Rights Commission, n.d.-c).

Some examples of behaviours and attitudes that are considered bullying in the workplace are repeated hurtful comments or attacks, and ridicule of others' work or personal attributes (such as family, sex, sexuality, gender identity, race, culture, education or economic background).

Other behaviours considered to be bullying include exclusion from work-related activities, psychological harassment and intimidation. Additionally, assigning pointless tasks unrelated to the job, giving impossible tasks, deliberately altering work hours or schedule to create difficulties, withholding necessary information, physical aggression, and using or threatening with weapons are all forms of bullying. Furthermore, initiation or hazing rituals that involve humiliating or inappropriate actions to gain team acceptance also constitute workplace harassment (Australian Human Rights Commission, n.d.-c).

Lastly, **harassment** involves unfavourable treatment based on characteristics such as race, sex, age, disability, sexual orientation or gender identity (Australian Human Rights

Commission, n.d.-e). A single incident can be considered harassment. Examples include telling racially insulting jokes, sending sexually suggestive messages, displaying offensive images or making derogatory racial comments. In Australia, there are specific laws addressing certain types of harassment: sexual harassment, disability-based harassment and racial hatred.

Discrimination and bullying can intersect with **racism** when individuals experience both racial discrimination (Australian Human Rights Commission, n.d.-b) and targeted bullying based on race or ethnicity (Australian Human Rights Commission, n.d.-c). This intersectionality highlights how systemic racism can contribute to discriminatory practices that fuel bullying behaviours, exacerbating inequalities and harming individuals' mental, emotional and physical wellbeing. The systematic review and update to the literature in Chapter Three explain these concepts in detail.

1.5 Definition of and rationale for the use of cultural competence and development of concept of intra-professional cultural competence

The concept of "cultural competence" was first introduced in the 1970s, primarily focusing on working with immigrant patients (Leininger, 1966, 1978). Over the years, this concept has evolved, with numerous authors and researchers contributing to its clarification and enhancement. However, some scholars have raised concerns about the use of this concept, arguing that it is static and may increase the risk of stereotyping communities and individuals. The claim that the concept of cultural competence is static has been supported by numerous authors (Furlong & Wight, 2011; Herring et al., 2013). However, this critique is predominantly found in studies focused on working with Aboriginal and Māori populations. Some other authors claim that, as it is impossible to be knowledgeable about all cultures, then knowing more about certain cultures may increase the risk of stereotyping, stigmatisation and racism from healthcare professionals to patients (Isaacson, 2014; Kumagai & Lypson, 2009; Lekas et al., 2020). But these studies are focused on the delivery of care.

Cultural humility (Tervalon & Murray-García, 1998), cultural safety (Papps & Ramsden, 1996) and cultural sensitivity (Bennet, 1986) are terms that have been used to complement or improve the concept of cultural competence. Cultural humility was initially proposed to be used for medical education (Tervalon & Murray-García, 1998). Similarly, cultural safety

emerged in 1989 in New Zealand as a strategy used to address healthcare of the Aboriginal population (Papps & Ramsden, 1996). The foundations of both concepts rely on the imbalance in power that may occur in a clinical encounter between a healthcare professional and patients or users. The concept of cultural safety is mostly used today to address healthcare of indigenous populations (Curtis et al., 2019) and it is currently used in post-colonial countries such as Australia (Australian Institute of Health and Welfare, 2023), New Zealand (Health Quality and Safety Commission, 2023) and Canada (Public Health Agency of Canada, 2023).

Cultural humility is defined as "a lifelong commitment to self-evaluation and critique, to redressing power imbalances in the physician and patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-García, 1998, p. 123). In other words, cultural humility is a lifelong learning process, requiring the commitment to constantly reflect on and self-evaluate actions, and it requires a personal transformation (Chávez, 2018). The attributes of cultural humility are openness, self-awareness, egolessness, supportive interactions, and self-reflection and critique (Foronda et al., 2016). However, cultural humility does not offer an alternative for those professionals who are not willing to learn from others and those who do not want to commit to a lifelong self-reflection process, but still have to work in multicultural teams.

The cultural humility theory of Foronda (2020) is a refined theory developed by blending Leininger's cultural care theory (1998, 1996, 2002) with concepts from the work of Tervalon and Murray-García (1998), Yeager and Bauer-Wu (2013), Foronda, Baptiste, Reinholdt and Ousman (2016), and Cross et al. (1989). The purpose of this refined cultural humility theory is to assist healthcare professionals in identifying instances where they hold power over their patients or students, and to encourage them to adopt openness, self-awareness, humility and adaptability. The author, Foronda, also identified a limitation by saying that, while this theory was informed by evidence, it remains untested (Foronda, 2020).

The selection of "cultural competence" as the preferred term in this thesis is driven by the primary focus of this research, which is the relationships between nurses. Nurses in theory hold similar levels of power, and their relationships and their interactions are located in a professional setting rather than in a clinical encounter with a client or patient as such. The

concept of competence refers to the possession of suitable skills, knowledge or abilities needed to perform a task or fulfil a role effectively. It is a broader concept that encompasses the overall capability or suitability for a particular purpose or role. Taking this into account, it is possible to be trained in acquiring this ability.

There are more than 25 different models pertaining to cultural competence. Examples include models by Kleinman and Benson (2006), Leininger (1978), Campinha-Bacote (1999, 2002, 2018), Papadopoulos et al. (Papadopoulos, 2018; Papadopoulos et al., 1998), Purnell (Purnell, 2002; Purnell & Fenkl, 2021) and Cross et al. (1989). There are some similarities and differences between them, but the focus, the target population and the characteristics of each may vary. For instance, Kleinman's and Purnell's models (Kleinman & Benson, 2006; Purnell, 2002; Purnell & Fenkl, 2021) were developed as a practice tool for clinical encounters, while the models of Papadopoulos et al. (Papadopoulos, 2018; Papadopoulos et al., 1998) and Cross et al. (1989) were created for training providers. Thus, since its first mention in the 1970s, the concept of cultural competence has evolved significantly. Numerous authors have offered their perspectives and definitions, contributing to a more comprehensive understanding of the term. The literature in the field is so abundant that only some examples are provided here. For instance, Campinha-Bacote (2002) determines that cultural competence is an ongoing process, rather than a one-time occurrence, comprising five elements: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Cultural competence has been described also as a multifaceted educational process encompassing cognitive, practical and affective domains, where confidence or transcultural skills play a significant role (Jeffreys and Dogan, 2012). Other authors state that cultural competence is an ongoing, never-ending process rather than a static outcome (Crigger et al., 2006; Greene-Moton & Minkler, 2020; Isaacson, 2014).

It is important to notice that there is no consensus about the use of any of these terms. Some authors argue that cultural humility is complementary to cultural competence, calling it "competemility" (Campinha-Bacote, 2018; Nguyen et al., 2021; Stubbe, 2020). Others consider cultural humility a replacement for cultural competence (Jang, 2023; Lekas et al., 2020), others consider cultural humility a component of cultural competence (Danso, 2018; Ross, 2010), and for others, it does not seem to offer significant practical benefits when compared to cultural competence (Danso, 2018).

For the purpose of this research, the concept of intra-professional cultural competence (IPCC) was developed from and based on the work of Cross et al. (1989) in which cultural competence is defined as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enable that system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13). The definition of IPCC adapted here is: "A set of congruent behaviours and attitudes that enable professionals to work respectfully and effectively in cross-cultural situations". This definition is primarily focused on interactions of nurses in the work setting and could be equally applied to other professionals working in similar positions of relatively equal power. The broad focus of this research is the interaction of IQNs and locally qualified nurses, and for this reason, cultural competence is the preferred term.

The selection of the concept of "cultural competence" (adapted to IPCC) is grounded in the demographics of this study population, where, in theory, nurses hold similar levels of power. This thesis relies on definitions and uses of the terms such as "racism", "discrimination", "bullying" and "harassment", as defined by the Australian Human Rights Commission (Australian Human Rights Commission, n.d.-a, n.d.-c, n.d.-d, n.d.-e) and bodies such as the Nursing and Midwifery Board of Australia (NMBA, 2022a). These bodies condemn harmful behaviours that ultimately undermine high quality nursing care which is grounded in core values of respect and professionalism.

Cultural competence is understood as the basic skills, knowledge or abilities that nurses need to demonstrate to work respectfully and effectively in cross-cultural situations. In nursing, the failure to practise IPCC within the workplace can result in detrimental consequences for patients and the overall quality of care. The negative consequences of bullying in the workplace are clear in relation to the negative impacts on the physical and psychological health of the victim and witness (Báez-León et al., 2016; Cardoso et al., 2016; Holm et al., 2023; Hong et al., 2022), and the negative effects on work environment and performance. Nurses who have experienced bullying have poorer overall health (Karatza et al., 2016; Sauer & McCoy, 2017). In relation to the work environment and performance, bullying has also been linked to patient safety issues (Anusiewicz et al., 2020; Pogue et al., 2022), medical errors (Hartin et al., 2018; Wright & Khatri, 2015), reduction in quality of care (Anusiewicz et al., 2020; Ekici & Beder, 2014; Hartin et al., 2018; Pogue et al., 2022), decreased productivity

(Hartin et al., 2018), reduction in communication (Anusiewicz et al., 2020; Wright & Khatri, 2015), and consequently, less teamwork and sense of community (Crawford et al., 2019; Ekici & Beder, 2014). Additionally, bullying negatively impacts job satisfaction (Brewer et al., 2020), increases absenteeism (Brewer et al., 2020; Crawford et al., 2019; Hartin et al., 2018; Lever et al., 2019), increases turnover intention (Blackstock et al., 2015; Crawford et al., 2019; Hartin et al., 2018; Kim et al., 2019), and affects the professional quality of life (Hartin et al., 2018; Kim et al., 2019). Therefore, this thesis argues that IPCC should be viewed as an obligation and a fundamental standard for practice, rather than relying on individual traits such as self-awareness, openness and ongoing commitment to self-evaluation and critique.

1.6 Research gaps and rationale

After completing the systematic review presented in Chapter Two and updating the literature on the experiences of IQNs in Australia, it is clear that certain barriers to integration have been consistently mentioned in the literature since as early as 1996 (Jackson, 1996). These barriers include racism, discrimination, bullying and harassment.

Despite the increase in the number of IQNs in Australia over the past two decades and the diversification of their countries of origin, consistent data confirms the persistence of these barriers. And despite two decades of research, these barriers remain prevalent in the Australian healthcare setting. The results of the systematic review were consistent with earlier findings, highlighting the prevalence of racism, discrimination, bullying and harassment within the nursing profession in Australia. This situation prompted further questions about the measures taken to address these issues through regulatory documents, the education of locally qualified nurses and clinical practice.

This led to the formulation of the research aims and subsequent research objectives presented in Section 1.8.

1.7 Research aims

The studies in this thesis aimed to:

- Determine the barriers and facilitators to the professional integration of IQNs in Australia

- Identify the cultural and linguistic characteristics of the nursing workforce in Australia
- Ascertain the steps taken by regulators to address the barriers and facilitators to the professional integration of IQNs in Australia and the effectiveness of this approach
- Explore the views of educational and regulatory experts in relation to the elements of IPCC (mutual collaboration and professional relationships; prevention of racism and discrimination (R&D) and bullying and harassment (B&H) among nurses; respecting values, attitudes and beliefs of colleagues that may differ across cultures and responding appropriately to cross-cultural interactions with colleagues) in Australia

- Analyse the experiences of the elements of IPCC in one school of nursing in relation to clinical practice and educational preparation.

1.8 Research objectives

The objectives of this research were:

- To systematically review the evidence on barriers and facilitators to the professional integration of IQNs
- To quantitatively investigate the CALD workforce in Australia
- To study key regulatory documents to identify any steps taken by regulators in three countries to introduce strategies to address the barriers and facilitators to the professional integration of IQNs. To determine the effectiveness of this approach
- To qualitatively analyse the perspectives of three Australian regulatory experts in relation to the elements of IPCC in Australia
- To qualitatively analyse whether the elements of IPCC operate in one school of nursing in relation to educational preparation and clinical practice.

1.9 Structure of the thesis and brief explanation of each study

This thesis is structured as follows:

This chapter, **Chapter One** provides an overview of relevant themes related to nursing in Australia and nurse migration. It addresses key concepts such as acculturation, racism, bullying and discrimination. Furthermore, it explains the rationale for using the term "cultural competence" over other related concepts, and introduces the concept of intra-professional cultural competence, or IPCC. This chapter also presents the research gap and the research aims, along with the thesis structure and discussion of my position as the author.

Chapter Two covers the research methods. In this chapter, an overview of the methodologies used in the four studies is provided, with particular emphasis on the methods employed in Stud Four.

Chapter Three presents findings from Study One, which addresses the first research question: What are the barriers and facilitators to the professional integration of internationally qualified nurses in Australia? This study includes the publication of a *research protocol* and a *systematic review*. Additionally, a publication statement and a linking paragraph are provided to connect the findings and contextualise the study within the broader research framework. The final section of the chapter presents an updated review of the literature since the publication of the original review.

Chapter Four addresses the second research question: What are the cultural and linguistic characteristics of the nursing workforce in Australia? The study presented in this chapter (Study Two) aimed to explore the cultural and linguistic profile of the nursing workforce in Australia through a secondary data analysis. Additionally, the chapter introduces the concept of intra-professional cultural competence, along with the rationale for its use in linking the findings to the broader body of research. The chapter also presents an exploration of IPCC as a strategy to support Australia's CALD nursing workforce.

Chapter Five presents the findings of Study Thee, which addresses the third and fourth research questions: What steps have been taken by regulators to address the barriers and facilitators to the professional integration of internationally qualified nurses in Australia? and

how effective has this approach been? The chapter presents a second publication, which examines nursing regulatory documents in the light of the elements of IPCC and compares findings across three countries: the UK, New Zealand and Australia. The chapter also includes a publication statement, a linkage paragraph connecting the article to the broader body of research, and an update of the literature that has emerged since the article's publication.

Chapter Six presents the findings of Study Four, which addresses the fifth and sixth research questions: What are the views of educational and regulatory experts in relation to the elements of intra-professional cultural competence (IPCC) in Australia? and what are the experiences of the elements of IPCC in one school of nursing in relation to educational preparation and clinical practice? This chapter examines the registered nurse baccalaureate curriculum, particularly the clinical placements of nursing students, to understand how the elements of IPCC are taught in one Australian school of nursing. This exploratory qualitative study also involved interviews with experts, academics and clinical educators to elicit their views on the elements of IPCC in Australia.

Chapter Seven presents the discussion and conclusion. This chapter addresses the limitations of the thesis and triangulates the findings of each study, highlighting their originality and significance. It concludes with recommendations and implications for further research.

1.10 Positioning myself in the study: risks and benefits

To establish my position as a researcher, I begin by delineating my unique journey. I am a temporary migrant nurse, an international student, and the mother of two young boys who, prior to our relocation, had no proficiency in English. I also have a supportive and generous husband. With family and friends residing 13,000 kilometres away in Chile, my journey to Australia is marked by distance, virtual and in-person friendship, spelling and pronunciation mistakes, and cultural, professional and personal learning.

Before embarking on this academic pursuit, I held an academic position at the Nursing Department of the University of Chile, where, since 2007, I served diligently as a nursing academic. My tenure culminated in the role of Vice Director of the School of Nursing. During 2021, I won a full scholarship to pursue doctoral studies in Australia. Notably, the first

10 months of my PhD coincided with the onset of the COVID-19 pandemic, a detail of significance as it unfolded against the closure of Australian borders. As an IQN, I embarked on my academic journey in Australia with the aspiration of exploring the professional integration of nurses like me into the Australian healthcare system. However, my own transition to this new environment exposed me to the profound challenges and confusion faced by many migrant families. Every aspect of daily life posed a challenge, from navigating cultural differences and understanding the health system, to adapting to local routines, using public transport and enrolling my children in school.

Seeking to increase my professional experience in nursing education, I pursued opportunities to contribute to my field. Yet, my initial attempts to secure employment were discouraging. During an online job interview, I was confronted with the stark assertion that my expertise held little relevance in the Australian context. This encounter dealt a significant blow to my confidence. This struggle alerted me to some of the barriers faced by IQNs seeking to establish themselves within the Australian healthcare landscape.

Among the challenges of professional integration in Australia, I have endeavoured to maintain a positive outlook, and many other achievements have helped me to keep my confidence: I co-authored a book on nurse migration in Latin America, and I led a research network uniting academic nurses from 26 countries aiming to explore the intersection of nursing, migration and health. Beyond academia, I serve on a school committee dedicated to enhancing parental involvement and participation among immigrant families.

My personal journey mirrors the very challenges explored in my research – psychological adaptation, acculturation, language and communication misunderstandings, and the frustrating reality of unrecognised qualifications. This is the context in which my research was conducted, helped by the invaluable support of my supervisors who have taught me not only how to navigate academia in Australia at a high level, but also about honour, academic integrity, generosity, support and kindness, encouraging me to work hard and fostering an inextricable bond. I provide this background because it is important that I acknowledge that my work carries the risk of bias as a result of my own life story and the fact that I too am an IQN in Australia, facing similar situations to those that I research. With this in mind, my supervisors and I have taken measures to minimise the impact on my results and conclusions.

These measures are detailed in each chapter of this thesis but are also briefly summarised here.

Several measures were employed to minimise bias in this research. Self-reflection and transparency were integral components (Creswell, 2014; Neuman, 2021). I engaged in regular self-reflection to consider how my position as an IQN might influence my research. This reflective practice involved maintaining a research diary and a private blog where I documented my thoughts and reactions, particularly after reading studies that discussed barriers to professional integration such as racism, bullying and discrimination.

Transparency was another strategy (Creswell, 2014). My supervisors were fully informed of the potential biases, and my background as an IQN was explicitly noted as a possible source of bias in the ethics protocol and in each publication. I acknowledged my position as an IQN and engaged in discussions with my supervisors as to how it might affect the interpretation of the data. This transparent approach ensured that my potential biases were recognised and addressed throughout the research process. Additionally, triangulation of results was employed to minimise bias (Neuman, 2021). In all studies, my supervisors were involved to provide diverse perspectives and help identify potential biases. Three of the publications were submitted to peer-reviewed journals, where external experts could identify potential biases and suggest improvements. Furthermore, Study Four received approval from the University of Sydney **Ethics Committee**. This study had clear inclusion and exclusion criteria, ensuring that participants who met the criteria were included, regardless of whether they were internationally or locally qualified nurses. Finally, the analysis of the results was discussed and triangulated by three researchers to ensure accurate interpretation and minimise bias.

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Chapter Two

Methods

2.1 Introduction

Chapter Two outlines the methods used in the four studies included in this thesis. First, the strengths and limitations of the thesis will be detailed. Then the method and rationale for each study will be presented. For Studies One - the systematic review- and Study Three - the examination of regulatory documents- the methods of which are described in published articles within the thesis, the discussion here will be brief. Study Two - the workforce data analysis- has recently been submitted for publication and is currently under review. Study Four - the interviews with educational and regulatory experts, academics, and clinical educators- has not yet been submitted for publication due to time limitations. For these reasons, the methods for Studies Two and Four will be presented in greater detail.

2.2 Strengths and Limitations of the thesis

It is acknowledged that this thesis has strengths and limitations. While the positionality of the researcher may be view as a limitation. On the other hand, the access to respondents and the depth of perspectives attained could be attributed to the positionality of the researcher. Indeed, the positionality of the researcher as an internationally qualified nurse, meant that the thesis was able to bring great insight into the phenomena under investigation.

As outlined in Chapter One, the candidate is an internationally qualified nurse (IQN) with a culturally and linguistically diverse (CALD) background studying in Australia. The four studies undertaken in this thesis, along with the triangulation of the data, were conducted with the understanding that the candidate's position may introduce some bias, potentially influencing the analysis, conclusions and recommendations.

To minimise bias, my background as an IQN was explicitly acknowledged as a potential source of bias in each publication and detailed in the ethics protocol, as established in Chapter One of this thesis (Creswell, 2014). One strength of the thesis was that self-reflection was employed throughout the research process to recognise and address any potential biases (Creswell, 2014; Neuman, 2021). Also, triangulation of results with my supervisors was utilised across all studies to further mitigate bias (Neuman, 2021).

In Study One, which took the form of a systematic review, these limitations were explicitly declared. Additionally, it was noted that the search was conducted exclusively in the English language, and that the generalisability and transferability of findings was limited to nurses, excluding the experiences of other healthcare professionals. This Study underwent a peer review process prior to publication. Study Two – the workforce data analysis – was structured as a discussion paper, and self-reflection, transparency and triangulation of the analysis were key to minimise bias (Neuman, 2021).

In Study Three – the examination of regulatory documents – in addition to acknowledging that the candidate was an IQN with a CALD background, potential strengths and limitations were identified. Firstly, the findings may be specific to the context of nursing in the three countries studied (the UK, New Zealand and Australia), thereby limiting their generalisability to other settings. Secondly, our personal perspectives as researchers may have influenced the interpretation of content. However, we actively engaged in reflective practices to mitigate this risk throughout the interpretative process. This Study was also subjected to a peer review process prior to publication.

Study Four – the interviews with educational and regulatory experts, academics and clinical educators – was methodically designed and received ethical approval from the University of Sydney Human Research Ethics Committee. The Study implemented well-defined inclusion and exclusion criteria, ensuring that all eligible participants, whether IQNs or locally qualified nurses (LQNs), were included. One limitation of this Study is that the interviews were conducted by the candidate, for whom English is a second language. This is noteworthy, as nurses with foreign accents may be subject to accent-related discrimination, which could potentially influence the interview process (de Souza et al., 2016; New South Wales Nurses and Midwives' Association, 2019). However, it is important to mention that the candidate

experienced none of these situations during the interview process. Measures were implemented to address the potential for accent-related discrimination, including rehearsing the pronunciation of key terms prior to the interviews and maintaining a research journal to reflect on potential biases, which facilitated ongoing discussions with my supervisors.

Another limitation of Study Four is the restricted generalisability of the findings, as the Study was conducted within the context of a single nursing school. Additionally, while the number of academic and regulatory expert participants was relatively small, a strength of the study is that they were purposively chosen for their specialised expertise. Academics were selected based on their roles in leading cultural competence education, and regulatory experts were included due to their senior positions and extensive experience in the field. Finally, to enhance accuracy and minimise bias during the interpretive process, the Study findings were thoroughly reviewed and triangulated by my three supervisors.

2.3 Methodology

The research for this thesis used a mixed methods approach to explore the research questions. In mixed methods research, both quantitative and qualitative data are collected and analysed to explore an issue or problem that would benefit from both approaches (Creswell & Creswell, 2018; Neuman, 2021; Shorten & Smith, 2017). In this research, the design was intended to address a documented recognised problem, namely the difficulties that internationally qualified nurses (IQNs) experience during their professional integration into Australia, and to explore how that problem is or might be handled by regulators and educators. The methods used for the four studies were as follows. For Study One a systematic review was conducted following the Joanna Briggs Institute (JBI) guidelines (Lizarondo et al., 2020). The search strategy was developed using the Population, Phenomenon of Interest, Context and Setting (PICS) framework. For Study Two, secondary research of existing databases was employed (Manu & Akotia, 2021; Wickham, 2019). The databases used were the Australian Government Department of Health and Aged Care Nurses and Midwives Dashboard (Australian Government Department of Health and Aged Care, 2023) and the Organisation for Economic Co-operation and Development (OECD) Health Workforce Migration Dashboard (OECD, 2023). For Study Three, content analysis and latent coding was used to search health professional regulatory publications (Neuman, 2021), using the

elements of a concept developed as a potential solution to the identified difficulties. In Study Four, an exploratory, descriptive, qualitative research method was used (Neuman, 2021) to qualitatively analyse the perspectives of three Australian regulatory experts in relation to intra-professional cultural competence (IPCC) in Australia, and to analyse whether IPCC operates in one school of nursing in relation to clinical practice and educational preparation. The findings from the four studies were examined to determine the extent to which they addressed the research questions. These results were then repositioned within the broader context of the existing literature to further interpret and validate the conclusions. These conclusions are presented in Chapter 7.

2.4 Research methods and rationale

2.4.1 Research method and rationale for Study One

Study One - the systematic review- addressed the following research question: What are the barriers and facilitators to the professional integration of internationally qualified nurses (IQNs) in Australia?

This research question was answered by developing a protocol for and then undertaking a systematic review. This research culminated in the production of two papers:

> "Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: A mixed methods systematic review protocol"
>
> and
>
> "Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: A mixed methods systematic review".

Systematic reviews are a form of research synthesis designed to locate, appraise, and integrate evidence relevant to a specific research question or set of questions, with the ultimate goal of informing practice, policy, and future research directions (Munn et al., 2018). These reviews gather studies that meet predefined eligibility criteria and apply rigorous, transparent methods to minimise bias. A systematic review typically starts with a focused research question and is guided by a pre-established protocol. It formally evaluates the

quality of included studies and draws conclusions directly linked to the research question (Armstrong et al., 2011; Higgins & Thomas, 2019).

In contrast, scoping reviews are particularly useful for mapping the scope, characteristics, and volume of literature on a given topic—especially when the field is complex, emerging, or not yet well-defined. They provide an overview of the available evidence and are helpful for identifying research gaps and clarifying areas that may benefit from more targeted systematic reviews in the future (Armstrong et al., 2011).

Given the nature of this research, the systematic review methodology was selected. Our aim was to examine the professional integration of IQNs in Australia, a topic for which there is already a substantial and growing body of literature at both national and international levels. This existing evidence base enabled us to formulate a clearly defined research question and focus on synthesising the best available data within a specified timeframe and within the Australian context.

An initial literature search was conducted to develop the systematic review protocol. The method for this review followed the JBI process (Lizarondo et al., 2020). The review aimed to explore the barriers and facilitators experienced by IQNs during their professional integration into Australia.

The search strategy was developed using the PICS framework, and the search was conducted across six databases: Web of Science, Scopus, Informit, ProQuest, Ovid and CINAHL. For the assessment of methodological quality, the JBI Qualitative Checklist and Checklist for Analytical Cross-Sectional Studies were employed. Eight studies met the inclusion criteria; of these, seven used a qualitative approach, and one used a quantitative cross-sectional design. The synthesis was performed using a convergent integrated approach.

For more details about the method and rationale of this study, please refer to Chapter Three. The supplementary data are included in the appendices section in chapter Three. The supplementary data include: PRISMA 2020 checklist (Appendix 1); Search strategy, that was constructed using the scheme Population, Phenomenon of Interest, Context and Setting Search strategy (Appendix 2); Search outcome tables retrieve on June 6th, 2022, from OVID database (Appendix 3); List of studies not selected and the reason for their exclusion

(Appendix 4); JBI Critical appraisal checklist for qualitative research and JBI Critical Appraisal checklist for Analytical Cross-Sectional studies (Appendix 5) and JBI Data Extraction Tool for Research (Appendix 6).

2.4.2 Research method and rationale for Study Two

Study Two - the workforce data analysis- addressed the following research question: What are the cultural and linguistic characteristics of the nursing workforce in Australia?

The results of the systematic review, along with the analysis of literature on the integration of IQNs in Australia, raised questions about the composition of the Australian nursing workforce, specifically the proportion of IQNs and culturally and linguistically diverse (CALD) nurses, and prompted further exploration to shed light on the scope of this issue. Additionally, comparing the results of this systematic review with previously published reviews (Chun Tie et al., 2018; Konno, 2006; Ng Chok et al., 2018) highlighted recurrent findings, such as the personal factors influencing IQN integration, persistent barriers such as language and communication challenges, as well as the prevalence of racism, discrimination, bullying and harassment in nursing.

The initial aim of this second study was to determine the proportion of locally qualified nurses compared to IQNs. To achieve this, a detailed analysis of two dashboards was conducted: the Australian Government Department of Health and Aged Care Nurses and Midwives Dashboard (Australian Government Department of Health and Aged Care, 2023) and the OECD Health Workforce Migration Dashboard (OECD, 2023). Information from the OECD dashboard on Australia, covering the years 2017 to 2021, regarding the stock of foreign-born nurses and their countries of origin, was selected and transferred to an Excel file for further analysis. This is often described as secondary research, where existing databases are interrogated to answer further research questions. Secondary research entails examining specific issues by analysing pre-existing data or information that was initially collected or produced for a different purpose (Manu & Akotia, 2021; Wickham, 2019).

The Nurses and Midwives Dashboard provides six years of publicly available data on registered nurses (RNs), enrolled nurses, midwives and nurse practitioners. The dashboard enables additional data-filtering to include categories such as nurses who obtained their initial

qualification in Australia, those working in metropolitan areas, gender, average age, average weekly work hours, Australian-born individuals, and Australian-born Aboriginal and/or Torres Strait Islander individuals. It provides both the percentage and total numbers for each category. For this study, only data pertaining to RNs were selected. The chosen categories included RNs who obtained their initial qualification in Australia and RNs who were born in Australia. These totals were transferred to Excel, where additional categories were derived using simple calculations:

- Initial qualification overseas: This category was calculated by subtracting the number of RNs who obtained their initial qualification in Australia from the total nursing workforce for each year.
- Born overseas: This category was calculated by subtracting the number of RNs born in Australia from the total nursing workforce for each year.
- Overseas born with initial qualification in Australia: This category was calculated by subtracting the number of RNs with an initial qualification obtained overseas from the total number of overseas-born RNs.

The label "Initial qualification overseas" was renamed to "Internationally qualified nurses (IQNs)", and "Overseas born with initial qualification in Australia" was updated to "Overseas-born locally qualified nurses (OBLQNs)". The data analysis revealed that the combined total of IQNs and OBLQNs accounted for 43% of the nursing workforce in 2022. To contextualise the potential challenges faced by this multicultural nursing workforce, Study Two explored barriers encountered by CALD nursing students in Australia, alongside those faced by IQNs. It is possible that these two groups experience similar obstacles in their integration into the Australian nursing workforce.

There is known to be a positive impact on patient care delivery and overall wellbeing from intra-professional collaboration, team cohesion and a supportive work environment (Schön Persson et al., 2018; Ylitörmänen et al., 2023). Conversely, there are detrimental effects of racism, discrimination, bullying and harassment on both those directly affected and individuals with vicarious exposure to these experiences (Báez-León et al., 2016; Cardoso et al., 2016; Hong et al., 2022). Given that in 2022 nearly half the Australian nursing workforce can be estimated to have been born overseas, the candidate became interested in exploring

ideas that might address the recurrent problems of racism, discrimination, bullying and harassment, and developed the concept of intra-professional cultural competence (IPCC) as a potential strategy to address some of these issues and particularly to support the transition of CALD nurses.

Cross et al. (1989) defined cultural competence as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enable that system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13). Building on the concept of cultural competence described by Cross et al. (1989), this study proposes a new concept – intra-professional cultural competence (IPCC) – and modifies Cross et al.'s 1989 work to define IPCC as "A set of congruent behaviours and attitudes that enable professionals to work respectfully and effectively in cross-cultural situations".

The concept of cultural competence was chosen over other relevant terms (such as cultural humility or cultural safety) due to the greater probability of equal status between colleagues than between nurses and their patients (Papps & Ramsden, 1996; Tervalon & Murray-García, 1998). The term "competence" refers to having the knowledge, skills and attitudes necessary to perform a task or fulfil a role effectively (Nabizadeh-Gharghozar et al., 2021; Mrayyan et al., 2023). These competencies could arguably be developed through education and training. This rationale is further explained in Chapter Four. A paper from Study Two has recently been submitted for publication and is currently under review.

The data extracted for Study Two were reported in a discussion paper, providing background information, analysing relevant literature and databases, and explaining the rationale for proposing IPCC as a potential strategy to support the growing CALD nursing workforce.

2.4.3 Research method and rationale for Study Three

Study Three - the examination of regulatory documents- addressed the following research questions: What steps have been taken by regulators to address the barriers and facilitators to the professional integration of IQNs in Australia? and how effective has this approach been?

The systematic review in Study One (Correa-Betancour et al., 2024), along with comparisons to previous studies carried out in Australia (Chun Tie et al., 2018; Konno, 2006; Ng Chok et al.,

2018), identified significant barriers to the professional integration of IQNs, with racism, discrimination, bullying and harassment being frequently cited. Similarly, Study Two found that 43% of the Australian nursing workforce in 2022 came from CALD backgrounds, leading to the proposal of IPCC as a potential strategy to enhance nursing interactions and relationships, particularly to support the increasing CALD nursing workforce.

Study Three was designed to analyse the content of two sets of regulatory documents – the Standards for Practice and the Code of Conduct for nurses – in three similar jurisdictions: the UK, New Zealand and Australia. The aims were to ascertain the steps taken by regulators in each country to address the barriers and facilitators to the professional integration of IQNs, by determining the extent to which the foundations of IPCC are reflected, either explicitly or implicitly, within these documents. These particular documents were chosen because they stand as essential frameworks that guide professional nursing practice. While the overarching research is concerned with integration of IQNs in Australia, it was determined that analysing similar documents from two other countries that had high levels of IQNs might shed light on whether or not regulators perceived racism, discrimination, bullying and harassment as an issue for the profession and, if so, whether they took steps within their regulatory publications to address these behaviours.

Commonly, nursing regulatory bodies worldwide publish Standards for Practice and Codes of Conduct that vary depending on the jurisdiction. Standards are used to define expectations for nursing practice and conduct for regulatory purposes (Benton, 2011; Staunton & Chiarella, 2024). These standards serve as a guide for what society – including patients, families, colleagues and other healthcare professionals – can anticipate from the practice of RNs (Cashin et al., 2017). Codes of Conduct typically encompass minimum behavioural expectations that cover a range of areas, including patient care, professional relationships and scope of practice, among others. These serve as benchmarks against which individual behaviours are evaluated, with breaches potentially resulting in disciplinary actions by employers or regulators (Staunton & Chiarella, 2024). The Codes are considered fundamental minimum behavioural guidelines that nurses are expected to demonstrate in their daily activities (Cowin et al., 2019).

Study design

The design of this study used content analysis and latent coding (Neuman, 2021). Content analysis is a systematic method used to interpret and categorise content within documents, enabling researchers to identify patterns, themes and meanings in textual data. Using content analysis, it is possible to extract insights from written materials that may be implicit or difficult to detect through casual observation (Neuman, 2021). In a content analysis study, a coding system is essential to operationalise constructs (Neuman, 2021). For Study Three, the content was analysed using predetermined categories, guiding both the coding and classification process.

Based on the definition of cultural competence developed by Cross et al. (1989), the concept of intra-professional cultural competence was understood as "A set of congruent behaviours and attitudes that enable professionals to work respectfully and effectively in cross-cultural situations".

Data selection

Regulatory documents from the UK, New Zealand and Australia were selected for comparison. These countries were chosen due to their well-established pathways for IQN registration (Nursing and Midwifery Board of Australia, 2022b; Nursing and Midwifery Council, 2023; Nursing Council of New Zealand, n.d.). Additionally, each country relies significantly on attracting IQNs to support their healthcare systems (Scheffler & Arnold, 2019) and has high migration rates (OECD, 2022).

The definition of IPCC was disaggregated, and a coding system with four main themes was established to guide the analysis:

1. Code one: content related to mutual collaboration and professional relationships.
2. Code two: content referring to the prevention of racism and discrimination among nurses
3. Code three: content relevant to respecting values, attitudes and beliefs of colleagues that may differ across cultures
4. Code four: content referring to responding appropriately to cross-cultural interactions with colleagues.

Three sets of regulatory documents from the previously mentioned countries – the UK, New Zealand and Australia – were then analysed using the IPCC coding system. The source documents were:

- Standards for practice
  - *Future nurse: Standards of proficiency for registered nurses* (2018), published by the UK Nursing and Midwifery Council (NMC)
  - *Competencies for registered nurses* (2022), published by the Nursing Council of New Zealand (NCNZ)
  - *Registered nurse Standards for Practice* (2016), published by the Nursing and Midwifery Board of Australia's (NMBA)
- Codes of professional conduct
  - *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates* (2018), published by the UK NMC
  - *Code of Conduct for nurses* (2012), published by the NCNZ
  - *Code of Conduct for nurses* (2018), published by the NMBA.

Data collection and analysis

Data collection involved an online search of publicly available documents from the official websites of the selected organisations. Each document was read in full and extracted into separate files for the analysis. A thematic review process was applied to examine each document, aiming to identify elements of IPCC within the texts. Further details on the methods used in Study Three can be found in Chapter Five.

2.4.4 Research method and rationale for Study Four

Study Four - the interviews with educational and regulatory experts, academics, and clinical educators- addressed the following research questions: What are the views of educational and regulatory experts in relation to the elements of IPCC in Australia? and What are the experiences of the elements of IPCC in one school of nursing in relation to educational preparation and clinical practice?

Research objectives

The research objectives of Study Four were to qualitatively analyse the perspectives of three Australian regulatory experts in relation to IPCC in Australia, and to qualitatively analyse whether IPCC operates in one school of nursing in relation to educational preparation and clinical practice.

Research Design

A qualitative, exploratory and descriptive research design was employed (Neuman, 2021). This approach is well suited to addressing the research questions and objectives established for this study. Exploratory research expands on descriptive research by investigating the underlying reasons for specific occurrences, offering a deeper understanding of a particular topic (Creswell & Creswell, 2018; Neuman, 2021). Even though cultural competence is well understood, IPCC is a completely newly developed concept and would not be understood; therefore an exploratory research approach was considered appropriate. However, although cultural competence is well known, as it has been discussed in relation to nurse–patient interactions for many years (Cassidy, 2024; Qin, 2021; Sharifi et al., 2019; Young & Guo, 2016), it has not been applied to intra-professional relationships to the same extent.

Sampling

Study Four investigated the views of educational and regulatory experts in relation to the concept of IPCC in Australia by interviewing key regulatory experts, academics and clinical educators in relation to educational preparation and clinical practice in one school of nursing in Australia. The study focused on their opinions and experiences regarding the elements of IPCC and whether they encouraged these elements in their practice. As this was an exploratory study, nonprobability sampling was used, specifically convenience sampling. This method of sampling involves selecting participants based on their accessibility and availability. Since the aim of the study was not to generate a representative sample, convenience sampling was considered an appropriate choice for participant selection (Neuman, 2021).

Data collection

The exploratory study included interviews with three groups: the experts, the academics and the clinical educators. The semi-structured interviews were developed using data from the

systematic review (Study One) and the analysis of the NMBA Code of Conduct and Standards for Practice, which have been discussed in conjunction with those of the UK and New Zealand in Study Three. The questions relating to these topics differed for the three groups based on their roles. (The three sets of interview questions can be found in Appendix A).

The first group consisted of three experts who were purposively selected, based on their extensive experience working with key regulatory institutions for nursing in Australia. These experts were contacted via email by one of the candidate's supervisors, and upon agreeing to participate, they were provided with a Participant Information Statement (Appendix B), a Consent Form (Appendix C) and a set of questions (Appendix A). The questions were informed by the results of a systematic review (Correa-Betancour et al., 2024) and the NMBA Code of Conduct for Nurses (Nursing and Midwifery Board of Australia, 2022a). The signed consent forms were returned by email.

The second group of interviewees was two academics from the selected school of nursing who taught content related to cultural competence. These academics were identified by the Head of School and purposively contacted via email and invited to participate. When they agreed, the interviews were scheduled to take place online. The academics were selected for their understanding of the school's curriculum, and their questions were designed around the results of the systematic review described in Study One (Correa-Betancour et al., 2024), and the NMBA Code of Conduct (2022) and Standards for Practice (2016) (Nursing and Midwifery Board of Australia, 2016, 2022a), particularly in relation to cultural competence.

The third group of interviewees consisted of nine clinical educators who were employed casually for the selected school of nursing. They were contacted via an email initially sent by the school administrator and then re-circulated by the candidate, using a mailing list provided by the school's management office. The email included an invitation (Appendix D), a Participant Information Statement (Appendix B) and a Consent Form (Appendix C). Once a clinical educator agreed to participate, a mutually convenient time and location for the interview was arranged. The interview locations included the school of nursing building, the hospital where clinical placements occurred, or online via Google Meet. The Consent Form could be signed and returned by email, or printed and completed before the interview. Participants were not excluded based on age, years of experience, gender or country of initial

qualification. Clinical educators are responsible for supervising and addressing the clinical experiences that students encounter during their placements. A key aspect of their role is to model and uphold the behaviours outlined in the NMBA Code of Conduct (Nursing and Midwifery Board of Australia, 2022a), which include (*inter alia*) the requirement for cultural competence.

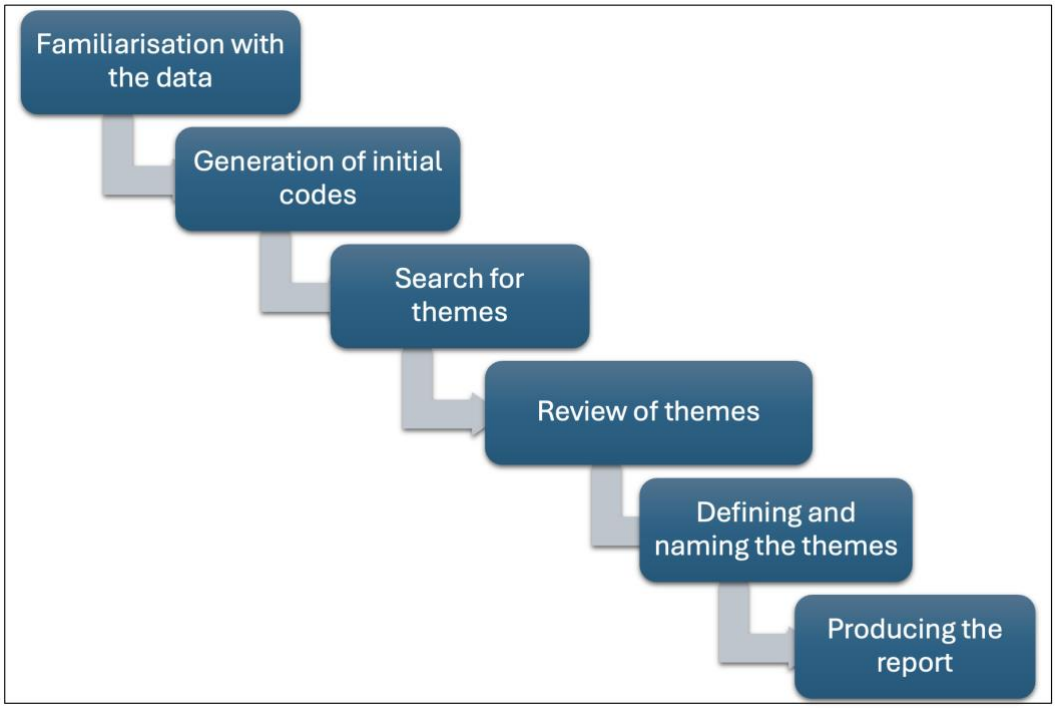
Data were collected for all three groups of interviewees through semi-structured interviews that were conducted from November 2023 to February 2024 (Appendix A). Semi-structured interviews provide a flexible and accessible platform for individuals to share their emotions, worldviews and personal experiences (Merriam & Tisdell, 2015; Neuman, 2021). The interviews typically lasted between 30 minutes and one hour. The interviews commenced with the collection of demographic information, followed by focused questions on whether there was anything like the concept of IPCC within the nursing curriculum (for all groups) and, additionally, in clinical settings (for academics and clinical educator groups). Each interview was recorded and subsequently transcribed by the candidate. The data collected were managed in accordance with the University of Sydney's Research Data Management guidelines (see Appendix E for The University of Sydney Human Research Ethics Committee approval – Approval No.: 2023/471, August 2023).

Data analysis

A thematic analysis was conducted following Braun and Clarke's (2006) inductive approach to generating codes and themes from qualitative data (Braun & Clarke, 2006). This thematic analysis uses a six-phase process of coding to identify relevant patterns. The phases consist of familiarisation with the data, generation of initial codes, search for themes, review of themes, defining and naming the themes, and producing the report (Figure 2.1) (Braun & Clarke, 2006). The candidate thoroughly examined the interview transcripts through multiple readings to ensure deep familiarity and immersion in the data. Initial codes were then generated and subsequently grouped into overarching themes using Microsoft Excel. The themes and subthemes were then refined and renamed. This preliminary draft was circulated and discussed with the candidate's supervisors for further refinement. The supervisors and candidate engaged in detailed discussions to compare and contrast the emerging themes,

ensuring that the analysis was both rigorous and of high quality. Once a collective agreement was reached, a conceptual model of the main themes was developed.

Figure 2.1. Representation of Braun and Clarke's (2006) inductive approach



As we analysed the findings, we realised that it was necessary to distinguish the concepts of racism and discrimination on the one hand, and bullying and harassment on the other in the findings, as the clinical educators in particular distinguished between them in their interviews. Racism and discrimination share some similarities, in that they are common mechanisms of prejudice and societal impact, leading to inequalities and reinforcing divisions in a social system (Australian Human Rights Commission, n.d.-d). Racism is a form of discrimination specifically based on race or ethnicity, while discrimination encompasses a broader range of characteristics like gender, age, disability and sexual orientation (Australian Human Rights Commission, n.d.-a). As a differentiation, bullying and harassment involve harmful behaviours that create hostile environments, exploit power imbalances, and negatively impact victims' mental and emotional health (Australian Human Rights Commission, n.d.-b, n.d.-c; Nursing and Midwifery Board of Australia, 2022a). However, not all bullying is based on racism or discrimination, although it is important to notice that in some cases it may be (Safe Work Australia, 2016).

Ethical considerations

Ethical considerations are essential in ensuring confidence in the validity and reliability of a study (Merriam & Tisdell, 2015). Ethical approval for this study was obtained from The University of Sydney Human Research Ethics Committee (Approval No.: 2023/471) in August 2023 (Appendix E). Key ethical considerations and mitigation strategies were carefully addressed in this research. Participants' dignity, autonomy and rights were respected throughout the process. Participants were not coerced or manipulated into participation, and the option of voluntary withdrawal was clearly communicated. A transparent protocol for recruitment and participation was established to avoid any undue influence or pressure, ensuring that participants had clear and accessible paths to withdraw from the study at any point. The candidate was not involved with the school of nursing included in the study, and did not know the study participants.

Participants were also provided with a Participant Consent Form (Appendix C). The Consent Form was presented in written form and signed voluntarily by each participant prior to the interviews, ensuring they had a clear understanding of the study's purpose, procedures, potential risks and benefits. After reading the consent form, the candidate allowed participants to ask questions and assured them of the confidentiality of their participation. Additionally, a Participant Information Statement (Appendix B) was provided. This was either emailed or given in printed form to each participant prior to the interview. This document detailed the purpose of the study, introduced the supervisors and candidate, outlined the eligibility criteria, explained what participation would involve, described the options for withdrawal, highlighted potential risks and benefits, and clarified how the provided information would be handled.

The contact details of the candidate and the lead supervisor were also provided to participants, in case they wished to access the final results of the study or had any further questions after the interview. The privacy and confidentiality of participants were strictly guaranteed. Personal data were handled securely and anonymised whenever possible, and a coding system was employed to protect participants' identities throughout the research process.

The candidate took measures to minimise the risk of physical, psychological or emotional harm to participants. Any potential risks were carefully assessed and balanced against the potential benefits. In cases where risks were identified, a clear mitigation strategy was established. For example, support services or referrals for participants and monitoring their wellbeing throughout the study were available to mitigate risks. However, no potential risks or costs were identified in relation to participating in this research.

Finally, the recorded data and transcripts were securely stored and accessed only by the research team, in accordance with the *Faculty of Medicine and Health – Sydney School of Health Sciences Research Data Management Provisions 2017* (2017). Research data will be stored online for a period of five years from the date of collection and will then be permanently deleted.

Trustworthiness

Trustworthiness, or rigour, in a study refers to the confidence in the data, interpretations and methods used to ensure the study's overall quality (Connelly, 2016). Conducting qualitative research ethically also involves ensuring validity and reliability (Merriam & Tisdell, 2015). Trustworthiness is assessed based on the criteria of credibility, transferability, dependability and confirmability, as introduced by Lincoln and Guba (1985). These key criteria were considered as follows:

> Credibility is how much the findings presented by the researchers truly and confidently represent what respondents said; in other words, the extent of confidence in the truth of the findings (Nowell et al., 2017). In this research triangulation and reflexivity were used to improve credibility (Ahmed, 2024; Nowell et al., 2017). The triangulation of findings enabled the supervisors and candidate to illuminate the analysis using different angles and to provide a more comprehensive analysis. Additionally, reflexivity was integrated into the process. By acknowledging that personal biases could lead to preconceptions or stigmatisation, the supervisors and candidate remained mindful of these potential influences. This awareness allowed for ongoing revisions and collaborative efforts to maintain objectivity throughout the research process.

Transferability refers to the external validity or generalisability of the research. By offering detailed contextual information, others can assess whether the findings are applicable to their own setting (Ahmed, 2024; Nowell et al., 2017). Rich, thick description is the most frequently mentioned approach (Merriam & Tisdell, 2015). In this regard, a thorough and detailed description of the research context, participant demographics, inclusion criteria and sampling methods are provided. It is also clearly stated that this is an exploratory study in a single setting, which is recognised as a potential limitation of this research.

Another approach to improve transferability involves paying close attention to the selection of the study sample. Including diverse variations in the sample, whether in terms of the study sites or the participants interviewed, opens the potential for a broader range of applications by readers of the research. This research incorporated the perspectives about IPCC of different actors (clinical educators, academics and regulatory experts), which may increase variation of the study sample, albeit small.

Dependability refers to the extent to which the research process was logically planned and thoroughly documented (Ahmed, 2024; Nowell et al., 2017). Dependability was ensured by maintaining a detailed diary that recorded the steps taken and the rationale behind the decisions made throughout the research process.

Confirmability was achieved by seeking feedback from peers or experts to validate the interpretation of the findings, ensuring that they are grounded in the data. This process aims to minimise bias and enhance the objectivity of the results (Ahmed, 2024; Nowell et al., 2017). In this research, confirmability was reached by seeking feedback from the supervisors, who validated the interpretation of the findings.

Limitations

Identifying and acknowledging limitations is essential for ensuring the transparency and credibility of the research. One limitation of this study is that the interviews were conducted by an IQN who speaks English as a second language, and it is known that nurses with foreign accents may experience accent discrimination (de Souza et al., 2016; New South Wales Nurses and Midwives' Association, 2019). This limitation was mitigated through several strategies,

including practising the pronunciation of key terms prior to the interviews, employing a rigorous research design, and involving multiple supervisors in the data analysis to ensure objectivity. Additionally, a research journal was maintained to document any potential biases that arose during the process for discussion with the research team. Another limitation is that the part of the study involving the analysis of student oversight in a baccalaureate nursing curriculum was conducted at only one school of nursing, which reduces the generalisability of the findings. Finally, although the numbers of academic and regulatory expert participants were small, they were purposively selected for their specific expertise. The academics were chosen because they identified themselves as being responsible for leading cultural competence education, while the regulatory experts were selected due to their seniority and extensive experience in the field.

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Chapter Three

Study One: What are the barriers and facilitators to the professional integration of internationally qualified nurses in Australia?

3.1 Introduction

Chapter Three presents the results of a systematic review that was conducted to answer the first research question: What are the barriers and facilitators to the professional integration of internationally qualified nurses (IQNs) in Australia? An initial search was conducted in six databases, and the search strategy was refined. The systematic review protocol was subsequently published, as was the systematic review itself.

This chapter includes the publication statement for the systematic review protocol, the published protocol and its references. This is followed by the publication statement for the systematic review, a discussion of the relevance of the systematic review to this study and the published systematic review. Conferences where these results were presented are also listed. The chapter concludes with an updated review of the literature published since the review's publication.

3.2 Systematic review protocol

3.2.1 Publication statement

Statement from co-authors confirming the authorship contribution of the PhD candidate:

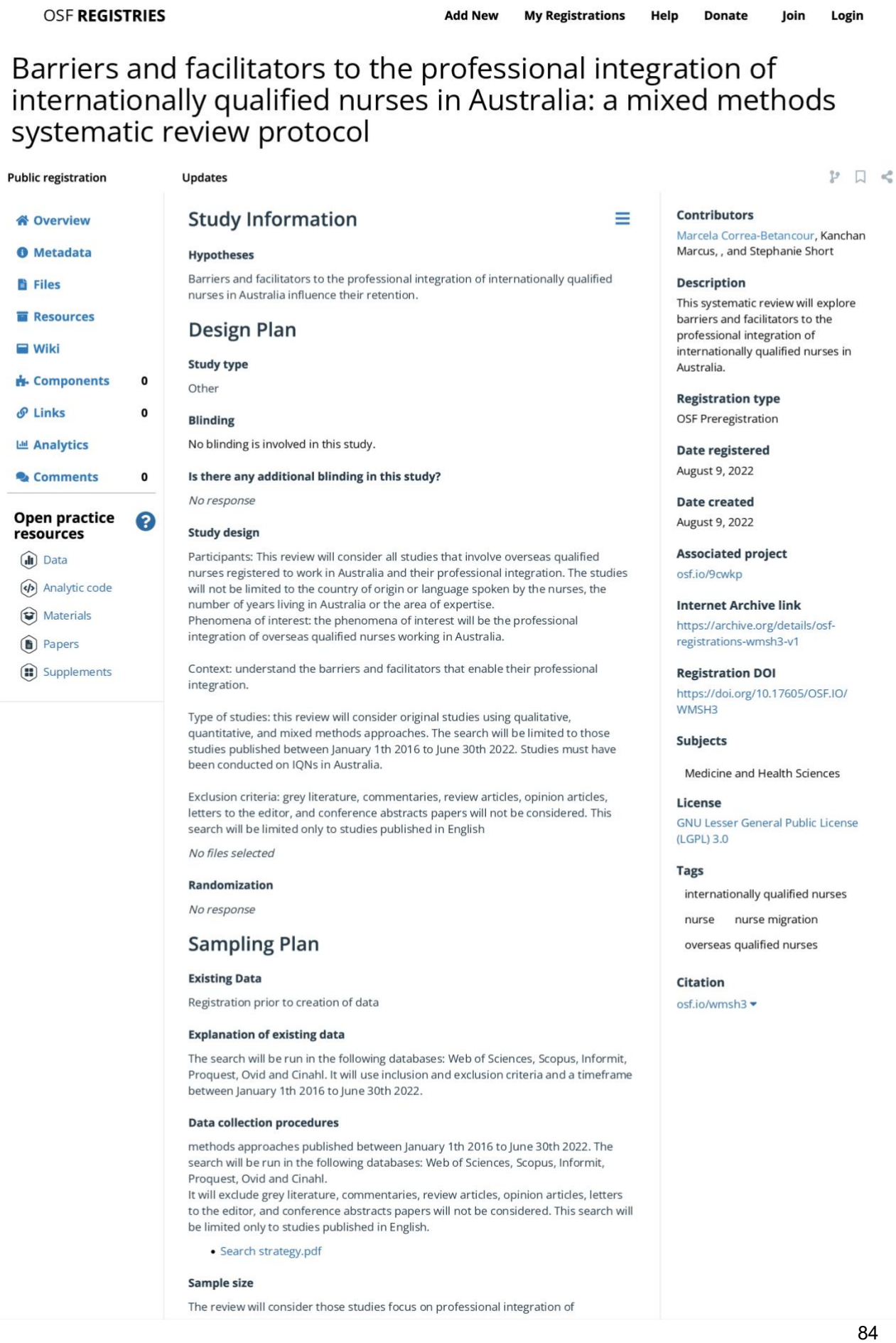
As co-authors of the manuscript

> **Correa-Betancour, M.,** Marcus, K., Balasubramanian, M., & Short, S. (2022, August 9). *Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: A mixed methods systematic review protocol*. OSF Registries. https://doi.org/10.17605/OSF.IO/WMSH3

we confirm that **Marcela Correa-Betancour** made the following contributions:

- Conception and design of the research
- Literature search
- Data collection
- Writing and revising the manuscript
- Final approval of the version to be published.

3.2.2 Published systematic review protocol



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Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: a mixed methods systematic review protocol

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Comments 0

Open practice resources
Data
Analytic code
Materials
Papers
Supplements

Study Information

Hypotheses

Barriers and facilitators to the professional integration of internationally qualified nurses in Australia influence their retention.

Design Plan

Study type

Other

Blinding

No blinding is involved in this study.

Is there any additional blinding in this study?

No response

Study design

Participants: This review will consider all studies that involve overseas qualified nurses registered to work in Australia and their professional integration. The studies will not be limited to the country of origin or language spoken by the nurses, the number of years living in Australia or the area of expertise.
Phenomena of interest: the phenomena of interest will be the professional integration of overseas qualified nurses working in Australia.

Context: understand the barriers and facilitators that enable their professional integration.

Type of studies: this review will consider original studies using qualitative, quantitative, and mixed methods approaches. The search will be limited to those studies published between January 1th 2016 to June 30th 2022. Studies must have been conducted on IQNs in Australia.

Exclusion criteria: grey literature, commentaries, review articles, opinion articles, letters to the editor, and conference abstracts papers will not be considered. This search will be limited only to studies published in English

No files selected

Randomization

No response

Sampling Plan

Existing Data

Registration prior to creation of data

Explanation of existing data

The search will be run in the following databases: Web of Sciences, Scopus, Informit, Proquest, Ovid and Cinahl. It will use inclusion and exclusion criteria and a timeframe between January 1th 2016 to June 30th 2022.

Data collection procedures

methods approaches published between January 1th 2016 to June 30th 2022. The search will be run in the following databases: Web of Sciences, Scopus, Informit, Proquest, Ovid and Cinahl.
It will exclude grey literature, commentaries, review articles, opinion articles, letters to the editor, and conference abstracts papers will not be considered. This search will be limited only to studies published in English.

- Search strategy.pdf

Sample size

The review will consider those studies focus on professional integration of

Contributors

Marcela Correa-Betancour, Kanchan Marcus, , and Stephanie Short

Description

This systematic review will explore barriers and facilitators to the professional integration of internationally qualified nurses in Australia.

Registration type

OSF Preregistration

Date registered

August 9, 2022

Date created

August 9, 2022

Associated project

osf.io/9cwkp

Internet Archive link

https://archive.org/details/osf-registrations-wmsh3-v1

Registration DOI

https://doi.org/10.17605/OSF.IO/WMSH3

Subjects

Medicine and Health Sciences

License

GNU Lesser General Public License (LGPL) 3.0

Tags

internationally qualified nurses
nurse nurse migration
overseas qualified nurses

Citation

osf.io/wmsh3

internationally qualified nurses in Australia

Sample size rationale

No response

Stopping rule

No response

Variables

Manipulated variables

The variables will be adaptation, adjustment, transition, experienc, job satisfaction, career aspiration, retention and discrimination.

No files selected

Measured variables

The barriers and facilitators will be identified.

No files selected

Indices

No response

No files selected

Analysis Plan

Statistical models

The data will be extracted by two independent reviewers using the JBI data extraction tool. The tool will be initially piloted. Data will be extracted using an excel table and include the author, year of publication, country and city where the study was carried out, details about the sample, methodology, and results. Finally, each study will be evaluated in terms of its credibility. Any disagreement that may arise between the reviewers will be solved by a third reviewer. In case of requiring any further information, the authors of the studies will be contacted for clarification.

No files selected

Transformations

Data integration will use a convergent integrated approach according to the JBI methodology for mixed methods systematic reviews using JBI SUMARI (Lockwood et al., 2015; Stern et al., 2021). The qualitative, quantitative, and mixed methos data will be assembled, then the data will be categorized and pooled together based on similarity. A set of integrated findings will be combined to produce an analysis

Inference criteria

No response

Data exclusion

All selected studies will be assessed for methodological quality using Yes, No, or Unclear options. This assessment will be done by two reviewers independently using the standardized JBI critical appraisal tool. Any disagreement that may appear between reviewers will be resolved by a third reviewer.

Missing data

In the case of needing more information from an specific study, the authors will be contacted using the correspondence email information on the publication.

Exploratory analysis

No response

Other

Other

No response

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TOP Guidelines | Reproducibility Project: Psychology | Reproducibility Project: Cancer Biology

Protocol references

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3.3 Systematic review

This systematic review exploring the barriers and facilitators to the professional integration of IQNs in Australia was published in 2024 in the *Australian Journal of Advanced Nursing*, a high impact nursing journal (impact factor: 1.4). The systematic review followed the Joanna Briggs Institute (JBI) methodological guidance for conducting mixed methods systematic reviews. The search was conducted in six databases (Web of Sciences, Scopus, Informit, ProQuest, Ovid and Cinahl). The selection of databases for the systematic review was guided by their emphasis on nursing-related literature and their ability to capture studies relevant to the Australian context. The JBI Checklist for Qualitative Research and Checklist for Analytical Cross Sectional Studies were used for methodological quality assessment.

The supplementary data is included in the appendices at the end of this chapter. These data includes: PRISMA 2020 checklist (Appendix 1); Search strategy, that was constructed using the scheme Population, Phenomenon of Interest, Context and Setting Search strategy (Appendix 2); Search outcome tables retrieve on June 6th, 2022, from OVID database (Appendix 3); List of studies not selected and the reason for their exclusion (Appendix 4); JBI Critical appraisal checklist for qualitative research and JBI Critical Appraisal checklist for Analytical Cross-Sectional studies (Appendix 5) and JBI Data Extraction Tool for Research (Appendix 6).

Eight studies met the inclusion criteria. Seven of them used a qualitative approach and one a quantitative cross-sectional design. A convergent integrated approach was used for the synthesis. The findings were organised into two main themes: individual factors and social factors. The first theme is linked to the personal capabilities of nurses to adapt to the new setting and consists of two subthemes: psychological adaptation, and communication and language. The second theme is linked to the interaction with others and the features of the nursing work setting. Three subthemes emerged: cultural differences in the nursing role; support, mentoring and appreciation; and discrimination and racism. The results are visually depicted using a Venn diagram model, illustrating the professional integration of IQNs in Australia. Implications for research policy and practice are also identified. This systematic review was double-blind peer reviewed and accepted for publication on 28 February 2024.

3.3.1 Relevance of the systematic review to this study

Numerous high-income countries heavily rely on recruiting IQNs. However, international literature underscores several barriers to the successful integration of IQNs in the work setting. Also, certain factors have been pinpointed as catalysts for professional integration. This mixed-methods systematic review aimed to identify both the obstacles and facilitators encountered by IQNs in their professional integration in Australia. Given the existence of prior publications in this domain, the review encompassed the period from 2016 to 2022. The findings not only aligned with previous research outcomes, but also illuminated the persistence of conduct related to discrimination and racism as one of the main barriers to professional integration. This publication underscores the critical importance of enhancing training in intra-professional cultural competence, with a particular emphasis on effectively collaborating with IQNs. Additionally, it advocates for enhancing the reporting mechanisms for instances of discrimination and racism within the workplace, and discussing the subsequent implications for patients, visitors and colleagues.

3.3.2 Publication statement

Statement from co-authors confirming the authorship contribution of the PhD candidate:

As co-authors of the manuscript

> **Correa-Betancour, M.,** Marcus, K., Balasubramanian, M., & Short, S. D. (2024). Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: A mixed methods systematic review. *Australian Journal of Advanced Nursing*, *41*(1), 39–53. https://doi.org/10.37464/2024.411.933

we confirm that **Marcela Correa-Betancour** made the following contributions:

- Conception and design of the research
- Literature search
- Data collection
- Analysis and interpretation of data
- Writing and revising the manuscript
- Critical appraisal of content
- Response to peer reviewers

- Final approval of the version to be published.

3.3.3 Published systematic review

REVIEWS AND DISCUSSION PAPERS

Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: a mixed methods systematic review

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ABSTRACT

Objective: This review aimed to better understand barriers to and facilitators of the professional integration of internationally qualified nurses (IQNs) in Australia.

Background: Nursing shortages are a critical global issue, including developed countries such as Australia, where about 20% of the nursing workforce has been trained overseas. IQNs face many challenges associated with the migration process itself; and their professional integration is crucial in retaining them in the workforce and in maintaining the quality of nursing care in Australia.

Study design and methods: This review followed the JBI methodology for mixed methods systematic review. Web of Sciences, Scopus, Informit, ProQuest, Ovid, and Cinahl databases were searched from inception. Qualitative, quantitative, and mixed methods original studies, published in English, were considered. Screening, data extraction and quality assessment were conducted independently by two reviewers. The assessment of methodological quality used the JBI Qualitative Checklist and Checklist for Analytical Cross-Sectional studies, and the data were extracted using the JBI data extraction tool. Disagreements were resolved by a third researcher and the synthesis used a convergent integrated approach.

Results: From an initial 110 studies, eight studies were included. Individual and social factors emerged as the main themes. The first theme was analysed in terms of two sub-themes: psychological adaptation plus communication and language. Social factors were analysed in terms of three sub-themes:
a) cultural differences in the nursing role;
b) support, mentoring and appreciation and
c) discrimination and racism.

Discussion: psychological adaptation and language proficiency are linked to personal factors. Cultural differences in the nursing role should be addressed with strong support and mentoring programs.

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Recognition of previous experience and appreciation of pre-existing skills are important facilitators. Discriminatory and racist behaviours continue in the work setting, yet are rarely reported.

Conclusion: Discrimination and racism from colleagues, co-workers, and patients should be addressed with a more direct approach than is currently in place. Training of locally and internationally qualified nurses in intraprofessional cultural competence may improve interaction and communication, reduce racism and discriminatory practices, and increase quality of care.

Implications for research, policy, and practice:

This research may be of interest to policy makers, healthcare educators, healthcare workforce planners and healthcare institutions. This study contributes to our understanding of the phenomena of nurse migration, retention, and professional integration, especially in high income countries. It is also a call to address the persistence of discriminatory and racist practices in the Australian context, as well as the education in intraprofessional cultural competence of some local nurses who work with IQNs.

What is already known about the topic?

- High-income countries like Australia rely on the attraction and retention of IQNs to meet their health outcomes.
- Personal characteristics, language proficiency, support and mentoring programs are strong facilitators for IQNs' professional integration.
- The persistence of discriminatory and racist practices are barriers to integration of IQNs in Australia.

What this paper adds:

- In Australia discrimination and racism continue to be dominant barriers to IQNs' professional integration.
- It is crucial to improve the reporting of situations involving discrimination and racism and discuss further consequences for patients, visitors, and co-workers.
- It is essential to promote training programs in intraprofessional cultural competence, and to focus on working with IQNs, as well as caring for patients from culturally and linguistically diverse (CALD) backgrounds.

Keywords: Australia, experience, foreign educated nurses, internationally qualified nurses, intra-professional cultural competence, professional integration, systematic review.

INTRODUCTION

The migration of nurses has been studied globally, particularly in the last 20 years.[1-3] The phenomenon has attracted significant attention, due to its consequences for both source and destination countries, in terms of health care coverage and ethical concerns regarding brain drain, brain gain and brain circulation.[3-5] The shortage of nurses has been a growing concern among experts, governments, and stakeholders in recent years and has become a common challenge for low, medium, and high-income countries worldwide.[6]

This situation was magnified during the COVID-19 pandemic, due to the prolonged exposure of nurses to stressful and difficult working conditions. Emergency and work conditions increased sick leave, burnout, and turnover globally.[6] A relevant report from the Nursing and Midwifery Council UK showed that, between the years 2019 and 2022, a growing proportion of nurses left their employment and changed their careers; for instance, over 25,000 nurses left the permanent register in 2022.[7]

The shortage of nurses is a challenge in developed countries more generally, where factors such as the ageing of the population, the increase in life expectancy, improvements in quality and safety standards, and the growth in the number of nursing hours required per patient have increased the demand for registered nurses. The International Council of Nurses (ICN) (2022) has made an urgent call for countries to plan and monitor their nursing workforce, in order to meet health care quality standards, especially in developed countries. Most of these nations rely on the attraction and retention of IQNs to meet the requirements of their health care systems.[8,9] As an example, nearly 40,000 registered nurse vacancies were reported in September 2021 in England and the need for 69,000 more nurses was projected by 2024-2025; 150,000 new nurses will be needed in Germany by 2025 and 65,000 nurses required in Switzerland by 2030.[6] Some of these high-income countries are known to adopt strongly competitive approaches to deal with nurse shortages and are making efforts to attract and retain IQNs. This situation will only intensify the demand for IQNs in countries such as Australia.

BACKGROUND

Australia, along with other high-income countries, such as Israel, Switzerland, Luxemburg, Ireland, Canada, the USA, and the UK, is heavily dependent on the employment of IQNs.[10,11] According to the Australian Government Department of Health (2022), the migration of IQNs has gradually increased over the last 20 years. IQNs now represent about 20% of the nursing workforce in Australia.[12, 13] Moreover, in sectors such as

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aged care, this percentage has reached 35% of the workforce.[14] In addition, a shortfall of nurses is projected by 2025 and it has been estimated that the nursing workforce must increase by 27% after that year.[15] Furthermore, it is expected that 20% of the Australian population will be over 65 years of age by 2031. This situation is magnified by the fact of Australia's high life expectancy: 85 years of age for women and 81 for men.[16] This is projected to increase the number of nursing hours required per patient. In 2022, the Australian Government announced that nurses would be employed twenty-four hours a day in each aged care home from July 2023, following the recommendation of the Aged Care Royal Commission.[17] All these factors indicate that the Australian health system would require the recruitment and retention of IQNs to be able to have sufficient numbers to ensure a high quality of nursing care, patient safety and responsive, humane care.

Social integration involves a wide range of challenges, which are experienced differently, depending on personal and external factors and may affect individuals independently of their educational or socioeconomic background. Social integration is said to have advantages for the improvement of mental and emotional health, interpersonal skills, and cross-cultural communication.[18] This is particularly important in the context of migration, since migration, which has been considered to be a social determinant of health in its own right, may constitute a risk to physical or psychological health.[19]

Professional integration into the workplace introduces a new range of challenges that can facilitate or interfere with the adaptation and retention of nurses in the selected workplace. Professional integration is a complex and multifactorial phenomenon, understood differently within different countries and institutions. In Canada, sociologists Neiterman and Bourgeault (2015) have defined 'professional integration' not only as the socialisation among professionals, but also as the active process of learning and understanding a work culture. This is a process that requires both adaptation to a new workplace setting and learning new skills, new responsibilities, and a new role.[20]

Despite the professional experiences of IQNs before migrating, there may be substantial differences in the scope of practice, the division and organisation of work and the nursing roles in a new country. In other words, professional integration is a process that comprises the acquisition of universal aspects of a new work environment, in this case, the Australian healthcare culture, and specific aspects of professional nursing practice linked to the professional ethos and professional identity of Australian nursing. Some of the issues most commonly listed by IQNs in developed countries relate to language and communication barriers,[21-23] social isolation,[21,23,24] discrimination and racism,[23,25] lack of recognition of nursing qualifications, lack of support and mentoring,[21, 23] underestimation of their skills by supervisors and colleagues,[23] and differences in nursing roles and professional responsibilities, compared to their country of origin.[22-24]

Some IQNs successfully overcome these difficulties, but a considerable proportion might leave Australia to find another destination country, return to their country of origin, choose a less qualified occupation, or work in a different field.[26] This situation of 'skills wastage' may be addressed by understanding these issues and generating policies, plans and processes to increase IQNs' retention and hence improve quality of care through improved staffing.

Three pertinent studies have illuminated the experiences of IQNs in Australia by systematising findings; the first in 2006,[26] and two in 2018.[28,29] These studies encompassed the years 1985 to 2003, 2007 to 2016 and up to and including 2016. These valuable studies emphasised the importance of orientation programs centred on individual needs, the necessity for an organisational approach and budgets that support nurse leaders and Australian nurses to integrate IQNs, to recognise their previous experiences and value differences, and to address the differences in expectations, especially regarding scope of practice. Finally, all three studies recognised the existence of normalised racial prejudice and exclusion from supervisors, co-workers, patients and visitors and identified how informal interactions with local nurses were difficult to establish in the workplace. These studies agreed on the importance of researching and understanding the phenomenon, in order to improve the social and professional integration processes for IQNs. The significance of this current review relies on three important points; the first is that this systematic review will focus on the studies published between 2016 to 2022. This timeframe means that none of the selected studies for this review were analysed in the three preceding reviews. Secondly, as stated earlier, the COVID-19 pandemic ignited a crisis in the nursing sector within the global context, increasing the demand for nurses, while many nurses in clinical roles have resigned. Thirdly, the Australian healthcare system currently needs to fill a wide range of nursing vacancies, for instance in the aged care sector. Thus, this review seeks to understand barriers and facilitators to the professional integration of IQNs in Australia in this particular context to contribute to understanding and addressing these phenomena.

This current review has been conducted following the COVID-19 pandemic, amidst pressing workforce shortages. The review seeks to expose and understand contemporary challenges for IQNs entering the workforce, with the aim of enabling more effective approaches to professional integration, in the interests of providing sustainable, high-quality, nursing care in Australia.

AIM

The aim of this systematic review was to synthesise evidence of the barriers to and facilitators for the professional integration of IQNs in Australia between 2016 to 2022.

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REVIEW QUESTIONS

The main question for this systematic review was: what are the current barriers and facilitators to the professional integration of IQNs in Australia?

INCLUSION CRITERIA

This systematic review considered studies between 2016 to 2022 that explored barriers and facilitators to the professional integration of IQNs working in Australia. The population for this study was IQNs working in Australia. The studies were not limited to the country of origin or language spoken by the nurses, the number of years living in Australia or their area of expertise. The phenomena of interest related to their professional integration. The context was not limited to any specific location in Australia, nor any clinical setting. The types of studies that this systematic review considered were original research published in the English language. There was no restriction of methodology imposed and the search included quantitative, qualitative, and mixed methods studies. Studies exploring experiences of both nurses and midwifes were excluded, as well as those studies analysing locally and internationally qualified nurses together.

METHODS

The review design followed the Joanna Briggs Institute (JBI) Mixed Methods Systematic Review process.[30] The PRISMA reporting guidelines were used to prepare this manuscript (Appendix 1).[31] The study protocol is available online,[32] and the data were synthetised using a convergent integrated approach. In the convergent integrated approach, the data from quantitative and qualitative research can be analysed and combined simultaneously to allow data transformation.[30,33] Synthesis of study results will be presented in narrative form.

SEARCH STRATEGY

A search was conducted between March and July 2022 in six electronic databases: Web of Science, Scopus, Informit, ProQuest, Ovid and CINAHL. As the most recent reviews relevant to this study covered the timespan up to 2016,[27-29] this review covered the timespan from 2016 to 30th June 2022. We limited the language requirements to studies published in English. We used Boolean operators to identify keywords and truncation symbols (*) to identify variations in root words. Some of the keywords used for the search were "*international** trained *nurs***", 'internationally qualified nurs **', "overseas trained *nurs ***", "*foreign educated nurs***", "*migran* nur***", *integration**, *adaptation**, *adjustment**, *transition**, *experienc**, "*job satisfaction***", "*career aspiration***", *retention**, *discrimination**. The search strategy is available in Appendix 2. The reference lists of selected articles were also screened for additional publications that met the inclusion criteria.

INFORMATION SOURCES

The databases that were searched included: Web of Science, Scopus, Informit, ProQuest, Ovid and CINAHL.

STUDY SELECTION

After finishing the search, the results were gathered, organised, and uploaded into COVIDENCE and Mendeley Reference Manager. Duplicates were removed and two researchers independently screened their abstracts and titles against the inclusion criteria for the review. The full texts of those studies that met the inclusion criteria were retrieved and assessed in detail against the inclusion criteria by two independent reviewers.

There was no disagreement amongst reviewers. However, a third reviewer was available in case of disagreement. Appendix 3 shows the search outcome table. The list of articles not selected and the reasons for their exclusion are available in appendix 4.

ASSESSMENT OF METHODOLOGICAL QUALITY

The Jonna Briggs Institute (JBI) Qualitative Checklist and Checklist for Analytical Cross-Sectional studies were used for critical appraisal of the studies that met the inclusion criteria (Appendix 5).[31] For the appraisal of the papers the options yes, no, or unclear were used. The option "Yes" indicated that the article contains a clear statement that directly responds to the question. The option "No", showed that the paper gave a negative response to the query and the option "unclear" showed that there was either confusing information offered in the research or no clear statement in the paper that answered the issue. Each study received a score between 0 and 1 indicating the proportion of "yes" scores overall in the JBI critical appraisal checklist (see details in Table 1 listed by date of publication).

TABLE 1. QUALITY APPRAISAL SCORES BY REVIEWERS LISTED BY DATE OF PUBLICATION

Studies (Author, Year)	Quality appraisal score	
	Reviewer 1	Reviewer 2
Crawford et al, 2016	0.6	0.6
Vafeas and Joyce, 2018	0.9	0.9
Mapedzahama et al, 2018	1	1
Philip, Woodward-Kron, Manias, et al., 2019	0.9	0.9
Philip, Woodward-Kron, & Manias, 2019	1	0.9
Dywili, O'Brien and Anderson, 2021	1	1
Zanjani et al, 2021 *	0.87	0.88
Joseph et al, 2022	1	0.8

* JBI critical appraisal checklist for analytical cross-sectional studies.

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DATA EXTRACTION

Qualitative and quantitative data were extracted from included studies by the first author using the JBI data extraction tool (Appendix 6).

The data were extracted using Excel under the following headings: author; title; barriers; facilitators; methods and design; sample setting; context, results (barriers and facilitators) and conclusions. Then results were organised around barriers and facilitators using a convergent approach and then main themes were identified.[34] None of the authors were contacted for missing information or additional data.

DATA TRANSFORMATION

Data from quantitative studies were transformed into narrative interpretation to facilitate the integration with data extracted from qualitative studies, using a convergent integrated synthesis approach and to answer the review question.[30]

DATA SYNTHESIS AND INTEGRATION

A convergent integrated approach was applied, according to the JBI methodology for mixed methods systematic review.[30] Convergent synthesis combines results from different sources of evidence, such as quantitative and qualitative, and compares and combines them to create a comprehensive summary of the evidence and to provide a more complete understanding of a research question.[30,35] Data were then categorised and grouped based on similarities to generate and integrate them in a narrative format.[30,35,36].

RESULTS

STUDY INCLUSION

The review search resulted in n=175 studies. Sixty duplicates were removed, and 115 abstract and title studies were screened by MC and KM. Nine studies were screened for full-text assessment, which resulted in seven studies being selected, based on inclusion criteria. One additional study was retrieved from the bibliography of the selected studies. In total n=8 studies were included for this systematic review. The quality appraisal applied shows a high quality of the included studies and a solid level of coincidence between the researchers. Figure 1 illustrates the search process of this systematic review.

METHODOLOGICAL QUALITY

The selected studies were analysed by two independent reviewers using The JBI Qualitative Checklist and Checklist for Analytical Cross-Sectional studies, as was explained in the Assessment of Methodological quality section. The appraisal used the terms Yes, No or Unclear. Papers were not excluded based on the score. The detail about the score of each reviewer can be found in appendix 7. The high-quality score obtained by most of the included studies impacted positively on the results.

CHARACTERISTICS OF INCLUDED STUDIES

Overall, eight studies met the inclusion criteria. Most of them relied on qualitative methods (n=7), such as semi-structured interviews, focus group interviews, participant observation and journals, and one study adopted a quantitative approach in a cross-sectional survey. There were no mixed method studies in the search. A summary of the included studies can be found in Table 2.

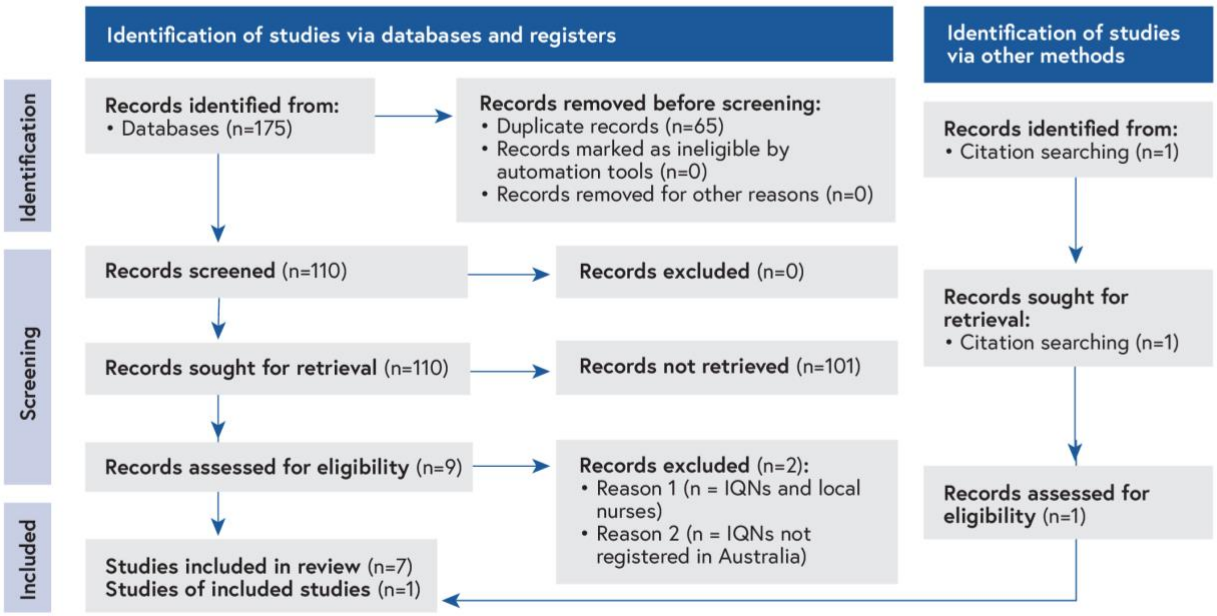


FIGURE 1. PRISMA 2020 FLOW DIAGRAM

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TABLE 2. SUMMARY OF INCLUDED STUDIES LISTED BY DATE OF PUBLICATION AND DESIGN

First author and year	Aim or objectives	Study type	Methodology	Sample size	Sample characteristic	Setting	Location	Main findings
Crawford et al, 2016	This study explores IQNs' experiences and perceptions of communicating with patients	Qualitative	Semi structured interviews And the use of a researcher journal	4	IQNs from 4 different countries (Zimbabwe, China, Iran and Philippines)	A 183-bed private acute care hospital in Sydney	Sydney, Australia	The findings were organised in one central theme called 'adjustment' which was connected to the other 4 themes: (1) professional experiences with communication (2) ways of showing respect (3) displaying empathy and (4) experiencing vulnerability.
Vafeas et al 2018	This study aimed to find similarities in the migration journeys of IQNs from the UK	Qualitative	Heuristic inquiry. It used snowball and purposive sample. Data collection was made through focus group interviews, individual semi-structured interviews, and an author journal.	21	IQNs from the UK	IQNs working in different clinical settings in Perth	Perth, Australia	There were three main findings as coping strategies. First the development of resilience; second, defining a new professional identity and third, the capacity of adaptation to the new reality. To achieve a successful experience, the feeling of belonging was key. Developing new friendships and finding a substitute family were considered significant priorities by the participants.
Mapedzahama et al, 2018	The goal was to fill a research gap by utilising the idea of "systemic ignorance" with the concepts of structural violence and faciality to interpret the experiences of black African IQNs who reported instances of racialisation and racial discrimination.	Qualitative	Unstructured conversational style, interviewee-guided interviews	14	IQNs from African countries who migrated to Australia under the skilled temporary visa (457).	It used personal networks and snowball sampling to recruit 14 black, 13 females, 1 male. The study was carried out in different clinical settings.	A large Australian metropolitan city in Australia	The lack of knowledge that black African IQNs have about their work environment is established, sustained, and replicated through actions such as holding complete and crucial information about the workplace, underestimating their expertise, maintaining organisational secrecy and racial stereotypes. Systemic ignorance is perpetuated by creating a perception of IQNs as both ignorant and untrustworthy. Consequently, IQNs are seen as incompetent and requiring constant monitoring. These perceptions result in the underutilisation of the skills of black IQNs and reinforce institutional racism. Simultaneously its undermining the economic advantages of migration and detracting from the rationale for enlisting black African IQNs in Australia's nursing workforce.

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First author and year	Aim or objectives	Study type	Methodology	Sample size	Sample characteristic	Setting	Location	Main findings
Philip, Woodward-Kron, Manias, et al., 2019	Investigated the factors that facilitate or impede clinical communication among IQNs using a community of practice perspective	Qualitative	Exploratory qualitative study. Semi -structured interviews. For the analysis open coding was used.	21	IQNs (4 males, 17 females) from non-English-speaking countries. Their ages ranged between 25 and 50 years of age. They had between 7 months to 20 years of nursing experience in Australia.	A semi- acute clinical setting at a major hospital in Melbourne.	Melbourne, Australia	The analysis produced two primary themes. The first theme encompassed the inherent characteristics of the individual, which acted as both impediments and facilitators. This theme had sub-themes of adaptability in language and preparedness. The second theme was centred on interactions with colleagues and patients, and had sub-themes of expectations, adjustment, and career advancement. Viewed through the lens of a Community of Practice, these themes had a relational aspect, with the IQNs' interactions with co-workers and patients having an effect on their growth in an unfamiliar healthcare setting.
Philip, Woodward-Kron, & Manias, 2019	The aim is to comprehend how overseas qualified nurses communicate within and between healthcare teams as they collaborate to provide patient care in Australian hospitals	Qualitative	This study used qualitative participant observation and discourse analysis. Data was collected through observation in periods ranging from 2.5-3 hours. Analysis was made using inductive an analytical framework from the data.	13	IQNs from India (n = 6), the Philippines (n = 6) and Nigeria (n = 1) participated.	An acute, subacute, and interventional cardiology settings in a Melbourne metropolitan hospital.	Melbourne, Australia	This study, based on genre analysis and observations, discovered that intra- and interprofessional communication was more frequently observed during the coordination of patient care and less often during the facilitation of interventions. Communication techniques ranged from structured interactions with the use of communication tools to spontaneous, unplanned interactions. An examination of the discourse patterns demonstrated that the efficacy of these interactions was influenced by hesitation, a lack of assertiveness, and a limited number of strategies to handle inadequate or aggressive communication from other team members. Additionally, suboptimal clinical communication with peers was not always attributable to IQNs from non-English-speaking backgrounds. Positive interpersonal interactions, including laughter, switching languages, and casual conversation, were apparent in conversations with nurses from comparable cultural backgrounds, but were infrequent with local colleagues.
Dywili et al, 2020	The study focused on the accounts of black sub-Saharan nurses who have worked in rural Australia and reported instances of racial discrimination	Qualitative	Qualitative hermeneutical phenomenological approach. Data were collected through face-to-face interviews and focus groups	18	IQNs from sub–Saharan Africa who migrated to Australia with the general skilled visa (457)	Different clinical settings	Rural New South Wales, Australia	Through the exploration of the experiences of these IQNs, issues related to race and skin colour emerged in the interactions between them and both their colleagues and patients. IQNs experienced instances of discrimination based on their race and skin colour, which made them feel unwelcome, untrusted, and undervalued. As a result, they adopted a range of coping mechanisms to adapt to being perceived differently.

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First author and year	Aim or objectives	Study type	Methodology	Sample size	Sample characteristic	Setting	Location	Main findings
Joseph et al, 2021.	The goal of this study was to investigate the experience of transition for Indian-trained nurses who are working in mental health settings in Australia	Qualitative	Hermeneutic phenomenological methodological approach. Purposive sampling. Data were collected through in-depth interviews and analysed with thematic analysis.	16	IQNs from India	Mental health setting across Australia	Australia	The results identified four themes. First, the experience of living in two cultures simultaneously; second, feelings of isolation and loneliness; third, experience discrimination, and finally, a sense of feeling incomplete.
Zanjani et al, 2021	The primary focus of this study was to investigate the factors that contribute to the sociocultural adaptation of IQNs to the Australian healthcare system. A secondary objective was to determine if there was a relationship between IQNs' sociocultural adaptation and their physical and mental wellbeing	Quantitative	Cross-sectional survey. Random sampling Plus 250 questionnaires sent to a target group, plus 50 questionnaires to personal contacts. Analysis was made using linear regression analysis	200	IQNs from countries where English was not their first language, and had completed bridging courses in Australia prior to registration	Online questionnaire	Australia	The questionnaire was completed by 200 participants. In the adjusted multivariate linear regression, job satisfaction (β=0.24,95%CI0.13to0.36), current work environment (β=0.27,95%CI0.05to0.49) and feeling at home (β=0.32,95%CI0.13to0.50) were positively associated with sociocultural adaptation. This association was independent. There was a negative association between Sociocultural adaptation and Perceived Stress Scale (r=−0.14,β=−0.16,p=0.04) and GHQ12(r=−0.36,p<0.001,β=−0.59). The most significant factors that impact IQNs' successful adaptation to the Australian healthcare system are job satisfaction and a sense of workplace support.

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FINDINGS OF THE REVIEW: INDIVIDUAL AND SOCIAL FACTORS.

Our synthesis was organised into two main themes relevant to the professional integration of IQNs in Australia: individual factors and social factors. Individual factors referred to those aspects of personality and life experience that affect IQNs' professional integration and was further divided into two subthemes: psychological adaptation and communication and language. The second theme, social factors, analysed the extent to which the nursing culture in Australia may affect IQNs' professional integration. It was divided into three sub-themes:

a) cultural differences in the nursing role;

b) support, mentoring and appreciation; and

c) racism and discrimination.

Figure 2 provides a graphic illustration of these main findings.

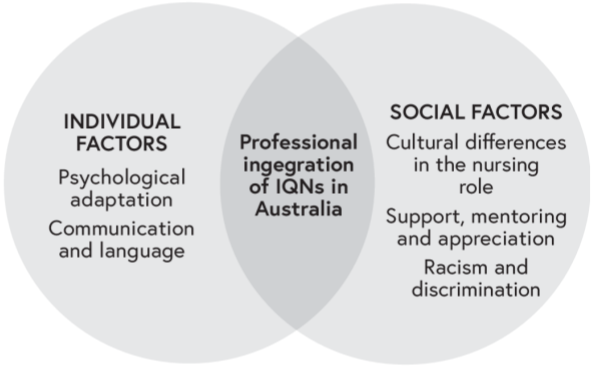


FIGURE 2. BARRIERS AND FACILITATORS TO THE PROFESSIONAL INTEGRATION OF IQNS IN AUSTRALIA

1. INDIVIDUAL FACTORS

a) Psychological adaptation

The studies identified that the IQNs had individual characteristics such as personalities and life histories that influenced the process of psychological adaptation. Characteristics included resilience, flexibility, and the ability to adjust to changing situations. IQNs had to adapt to the Australian culture,[37-41] to the hospital setting,[42,43] the Australian accent,[42] colloquialisms,[40, 42] and other foreign accents,[42,43] without their usual social support networks.

To be resilient to adapt to a new way of life, IQNs developed coping strategies such as to be flexible,[42,43] remain optimistic,[39] to make deliberate efforts to fit in socially and to be accepted.[37,39,40] Overall, IQNs had a positive view about life in Australia. They enjoyed living in the country, they felt safe, found places to practise their religion and were able to make new friends from other countries.[38,40] However, some of them felt themselves to be outsiders, had no sense of belonging or felt incomplete.[37,40] These feelings were stronger in the early stages of immigration and were softened as they became more adapted to the new location and could develop new social connections.[40] For others, they remained as an issue until they found a balance between living in two cultures.[37]

Loneliness is a common feeling experienced by IQNs. Families back in their home countries played an important role in supporting newly arrived IQNs and helped them to deal with isolation, especially for those who came from non-Western cultures.[37,38] Then, the studies reveal that IQNs utilised a range of strategies to cope with loneliness: for instance, to engage in hobbies, to make new friends, to make deliberate efforts to talk to colleagues and initiate social relationships or by having or making friends from the same country of origin, the diaspora. The last one positively contributed to feeling optimistic about living in Australia.[38]

Personal and professional identity are also modified in the migration process. One study found that IQNs had to re-build their personal identity, when they arrived in Australia, as part of the psychological adaptation in a new country.[40] Also, they had to re-build their professional identity once they entered the Australian healthcare setting. They had to gain respect from co-workers by demonstrating their knowledge and expertise in nursing, and this was independent of their qualifications and previous professional experience.[38,40]

Finally, the capacity to deal with stress influenced how IQNs displayed empathy, built therapeutic relationships, and provided emotional care.[42,43] The studies mentioned that working under pressure or having a high patient-to-nurse ratio, were situations that increased stress and negative perceptions about the nursing role and their capacity to deal with it. Other situations that increased stress, tension, or personal discomfort in non-English-speaking IQNs were linked to their foreign accents, mispronunciation, or rapid speech of patients, during extended verbal exchanges. In those situations, some patients reacted by showing frustration, intolerance, or even racist behaviours. Consequently, IQNs felt vulnerable and unable to provide adequate emotional care. Sociocultural adaptation was inversely proportional to stress level and directly proportional to reported better general health.[38]

b) Communication and language

Communication was a common issue in the studies, especially but not exclusively, for IQNs who came from non-English-speaking countries. The Australian accent,[43] the use of Australian colloquialisms,[40,43] patterns of communication in the hospital setting and strong accents of individuals from different nationalities,[42,43] were mentioned by native and non-native English speakers as barriers to fluent communication. The English proficiency levels described in the studies were variable, ranging from proficient or advanced to intermediate. In some cases, language barriers remained high, despite a reasonable length of time living in the country.[44]

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Communication and language barriers could negatively affect the interaction with patients and co-workers. Some participants mentioned that the differences in the tone of voice and the pattern of language used in the Australian clinical settings affected their understanding during interactions.[38,43] These situations caused feelings such as vulnerability and stress, and led them to avoid communicating with patients, as the patients tended to ask more questions and look for longer interactions. Such situations even brought up the idea of going home and giving up.[42] Communication was also affected when the IQNs did not feel well-adjusted into the workplace or when they felt concerned about their language fluency. For instance, the inability or the delay in finding the right word in a conversation generated tension with co-workers, increased concerns about their English proficiency and created self-doubt about their preparedness to work in Australia.[43] However, it has been suggested the poor communication with co-workers, including locally qualified nurses, were not always the sole responsibility of IQNs.[44]

IQNs utilised multiple strategies in attempting to improve language and communication. Some of them tried to adopt local communication patterns, slang, or colloquialism in general conversations, also they adopted the use of non-verbal communications and smiles or seeking clarification and paraphrasing.[43] Adjusting and improving their patterns of communication empowered IQNs to become more active members of the team. However, four studies revealed that local nurses tended to be reluctant to engage in social conversations with IQNs, regardless of whether they came from English or non-English-speaking backgrounds.[39,41,42,44] Interprofessional interactions tended to follow a communication protocol to minimise risks and avoid misinformation.[44] In those situations, the interaction between locally educated nurses and IQNs was minimal and limited to dealing with specific responsibilities. Only one study mentioned that being bilingual or multilingual worked as an enabling factor in gaining acceptance.[42]

The relative lack of hierarchy, and straightforward communication, in the Australian healthcare setting also required cultural adaptation from some IQNs.[42,43] Initially they interpreted it as rude and confronting but, after adjusting to this direct approach, they saw some benefits. The adaptation required the use of a range of strategies to develop self-awareness and made them conscious of barriers in communication and ways of overcoming them.[40,42,43]

2. SOCIAL FACTORS

a) Cultural differences in the nursing role

An IQN's cultural background (not only the language or foreign accent) influenced interaction with co-workers and patients, producing confusion and highlighting the importance of strong cultural orientation programs.[38,43,44] Studies described, for example, cultural differences in how to demonstrate respect and communicate with elder patients, co-workers, and supervisors, for instance by avoiding eye contact.[43] Also, there are cultural differences in establishing social and professional relationships. As an example of this, some cultures consider it inappropriate to argue with others or defend themselves, in order to avoid conflict and to demonstrate respect for hierarchy. Such situations make it challenging for IQNs to stand up for or even express themselves in the Australian work setting.

Finally, a recent study found that clinical encounters were different in their host countries, increasing confusion during the first stages of nursing practice in Australia.[42]

b) Support, mentoring and appreciation

Adequate team members support,[39, 42] comprehensive orientation programs and effective communication channels were facilitators to IQNs' professional integration.[38, 39, 41, 42] From a positive perspective, most IQNs believed that their working conditions were good and safe, and that their salaries were equivalent to their colleagues. They described their nursing roles as professionally rewarding and said that working in Australia provided them with opportunities to develop their nursing knowledge. As one participant said "*I still miss the UK but I'm happy now and I love the work here and the rest of the family are so happy here*".[40]

Lack of appreciation or trust,[39, 42, 43] loss of autonomy,[39, 40] and lack of recognition of previous knowledge and experiences were the concerns most frequently mentioned by IQNs regarding their professional integration.[39-41] Numerous studies found that IQNs perceived that they were not trusted and suffered a loss of autonomy in activities in which they had extensive experience prior to migrating. They also reported they felt more respected in their home countries and strongly believed that their expertise and knowledge was not being fully utilised by their employers. These situations produced disillusionment and professional dissonance, making the adjustment harder. For instance, one participant reported having changed jobs three times in a year until they found a place where their capabilities were valued.[40] Only one study found that their nursing experience prior to migration was positively welcomed by their managers, yet they still felt unwelcome and untrusted by co-workers and patients.[39] The sense of belonging increased when participants felt appreciated and, combined with the creation of new support networks, resulted in higher retention in the work setting and, in the country.[38, 40]

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c) Discrimination and racism

Discrimination and racism were the most frequently cited barriers affecting professional integration, referred to in six of the eight studies.[37-39,41,42,44]

Discrimination and racism were expressed in different ways: these included direct confrontation, insubordination from staff, hostile interactions with colleagues, lack of professional development opportunities, and non-inclusive behaviours. Also, patients reported discomfort about being nursed by IQNs, especially black nurses,[39,41] and those who came from non-English-speaking countries.[37,42,44] Two studies found that everyday racism in the work environment was naturalised and socially accepted.[39,41] In these studies, IQNs reported discrimination and racism from nursing colleagues, staff members, patients and visitors based on their skin colour, as they came from Africa. In one study, patients feared "the black nurse in charge of their care", and subordinates tended to be disrespectful or did not follow directions given by them.[39]

IQNs reacted differently to adjusting to situations involving discrimination and racism. Some of the strategies used were rationalisation of the experience offering an alternative nurse to oversee the care, avoiding exposure to abusive situations, focusing their minds on their migration goals, reciprocating with a similarly negative approach, or blocking negative attitudes.[37,39] Resilience, fortitude, and self-determination played important roles in overcoming these challenging situations. Sadly, in two studies those incidents involving discrimination or racism were not reported to supervisors.[39,43]

The consequences of discriminatory and racist behaviours had a direct negative impact on the mental health of IQNs.[37-39,41,42] In one study, a shocking 27% of the IQNs in the study experienced explicit racism within the workplace.[38]

DISCUSSION

This study has identified the elements that act as **barriers and facilitators** to the professional integration of IQNs in the provision of nursing care in Australia. In the previous section the findings retrieved from the studies are organised and explained in a narrative form. In this section, these results are interpreted, and it is established whether each of them is a barrier or a facilitator to professional integration.

PERSONAL FACTORS

Our findings are consistent with what the previous literature has revealed about immigrants' **psychological adaptation**. Previous studies in the field indicated that immigrants in general tend to display higher levels of anxiety and depressive symptoms as part of the psychological adaption in the host country: this phenomenon has been called acculturative stress.[45-47] The findings of this review suggest that the capacity to overcome acculturative stress relies on the personal attributes of IQNs, such as personality, life experiences, and family and social support. This is consistent with the extant literature.

The findings show that a significant barrier to professional integration is the lack of English language proficiency. An interesting finding is that this barrier, **communication and language,** is not exclusive to non-native English speakers, although it may be harder for them. Language proficiency is required to a successful transition to a new social context, and it is also required to adjust into the professional nursing setting.[48,49] This is particularly important when the results showed that IQNs made deliberate efforts to expand their communication skills, but some local nurses were not willing to improve mutual communication and understanding. There is evidence of accent discrimination in multicultural work settings where diverse languages are spoken[50]; similarly, some of these situations have been documented in the New South Wales healthcare settings.[51] We return to this issue further in analysing the barriers of racism and discrimination. Conversely, language proficiency becomes a facilitator for professional integration since it is directly related to social and economic achievements of immigrants.[48,49]

SOCIAL FACTORS

We turn now to focus on social factors relevant to the professional integration of IQNs in Australia. Some of the barriers that emerged regarding **cultural differences in the nursing role** were the influence of the culture of origin in daily-life interactions and the differences in clinical encounters. There are several similarities in the nursing role within the global context. However, there are also key differences that could be mentioned, such as the legal and professional responsibilities, and the scope of practice[52]. More specifically in the Australian context there were differences in the expectations regarding the behaviour of patients and families, the Australian approach to end-of-life care and medication management and pain thresholds of patients.[53] Consequently, a valuable facilitator would be to carry out comprehensive professional and cultural orientation programs for the IQNs. In addition, improving intra-professional cultural competence among locally trained nurses could be a crucial facilitator to professional integration. It is anticipated that this might increase the willingness of local nurses to communicate with and value IQNs, despite their accents or other barriers to communication. This in turn might avoid any form of accent discrimination.

Cultural competence is described as the ability to work effectively in situations when cultures play a role. Cultural competence has been defined as "a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals that enable that system, agency or professions to work effectively in cross-cultural situations".[54] Even though cultural safety and

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cultural competence have been part of the curriculum for locally educated Registered Nurses (RNs) in Australia, the main focus for cultural competence knowledge has been to support the indigenous and culturally and linguistically diverse (CALD) communities they care for, rather than their colleagues. However, this review identifies a poor application of cultural competence in the intra-professional relationships between nurses, especially where IQNs are involved. The Code of Conduct for Nurses of the Nursing and Midwifery Board of Australia (NMBA) (Principle 3) says that "Nurses engage with people as individuals in a culturally safe and respectful way, foster open, honest and compassionate **professional relationships** and adhere to their obligations about privacy and confidentiality" and the Australian Nursing and Midwifery Accreditation Council (ANMAC) requires cultural competence to be part of the BN curriculum.[55,56] Such requirements illustrate the expectation that Australian educated RNs will be able to recognise, avoid and report any form of racism and discrimination in the Australian work setting. Consequently, the focus of research and actions should be placed on understanding how this content is taught to Australian educated RNs and how they implement such requirements.

This emphasis on cultural competence is consistent with the findings of the three previous reviews conducted in Australia.[27-29] The Nursing and Midwifery Board includes in its program for IQNs seeking registration a two-module "Orientation to the health care in Australia". The first module has to be completed before registration and the second is required within the first six months of registration.[57] However, deeper, and more specifically oriented programs, would be valuable once IQNs enter a specific work setting to reinforce general content, but also to explain organisational, administrative, and cultural aspects of the role. A cultural orientation program would facilitate professional integration and increase awareness about cultural differences, biases.[53] In addition, it might identify implicit ethnocentrism that may be present in daily interactions.

When it comes to **support, mentoring and appreciation**, some of the *barriers* to professional integration identified in this study were the lack of recognition of previous experiences, the lack of autonomy and the perception of not being trusted. These were linked to the lack of support and the absence of mentoring programs. Under-appreciation and lack of recognition of previous IQNs' experience has been documented in Australia and in other countries such as the USA, Canada and the UK.[53,58]

The existence of a support programs or the guidance of a more experienced colleague were strong *facilitators* to professional integration. Feeling valued and having appropriate channels to obtain support and mentoring helped IQNs to increase adjustment to their local nursing role, to be more prepared to work independently, thereby increasing the sense of belonging and also retention.[59]

The final, and most significant, sub-theme is **discrimination and racism,** which was referred to in six of the eight studies.[37-39,41,42,44] The persistence of discrimination and racism is serious indeed and is identified as a fundamental barrier to professional integration. It was unearthed in the three previous studies and is (sadly) still present in the Australian nursing workforce setting.[27-29] A recent publication from the NSW Nurses and Midwives' Association (NSWNMA) found that about 25% of the participants had experienced racial discrimination on a monthly basis. However, only 31% of the total of these situations had been reported.[51]

The role that locally educated nurses are reported to play in displaying non-inclusive, discriminatory, and racist behaviour is the main barrier to professional integration identified in this study and therefore it is critical to explore the issue further. Additionally, the tendency to avoid interactions and display a non-inclusive behaviour towards IQNs may affect teamwork and may have negative consequences for patients' safety and quality of care.[60,61] Training in intra-professional cultural competence and improving intercultural skills for locally educated nurses could play a crucial part in a comprehensive approach and may constitute a significant facilitator to professional integration.

The studies have not referred to the consequences of experiencing discrimination or racism in the workplace. However, it is important to mention that, as many of the situations involving racism and discrimination were not reported to superiors, they could not be formally addressed by the institutions. There is an entire body of regulation focused on the control of racism and discrimination, and these concerns are part of the undergraduate programs regulated by ANMAC. As both the regulatory and the educational requirements already exist, it becomes important to improve channels to report them and discuss further consequences that contribute to educating patients, visitors, and co-workers.

This review has reinforced the findings from the previous publications in the field in Australia,[27-29] which used literature published after 2016 and was carried out after the COVID-19 crisis in a global context of higher demand for nurses.[6,7,10,11,17] Additionally, it revealed that acculturation in the workplace is infrequent, and that the integration of IQNs was understood as their own responsibility and was not always seen as a mutual process. Also, there was a lack of appreciation of the potential benefits that IQNs bring into the workplace, due to their different experiences and skills.

This review will hopefully serve to raise awareness about racism and discrimination, in order to encourage nurses to report these incidents and to intensify education to co-workers, patients, and visitors regarding the Nursing and Midwifery Board of Australia and The Australian Charter of Healthcare Rights and Responsibilities. [55,62]

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Additionally, the significance of this study highlights the importance of closely examining the training on intra-professional cultural competence for Australian qualified nurses. Whilst it is understood that the curricula are required to focus strongly on cultural competence with indigenous and CALD patient communities, this review suggests there may be a gap in these competencies when it comes to working with IQNs. Thus, the education of Australian qualified nurses needs to focus equally on working with colleagues from culturally and linguistically diverse backgrounds. This is critical in a country where more than 20% of the nursing workforce was trained overseas and more than 29.8% of the population was born overseas.[13,63,64] These results may be useful to understand in the Australian context but might also be valuable in other high-income countries receiving IQNs.

The findings of this systematic review have limitations. Firstly, generalisability and transferability are limited to nurses and do not explore the experience of other healthcare professionals. Secondly, the first author is herself an IQN in Australia, although she has tried to eliminate any bias by having a second and third reviewer to check her interpretation of the findings. Thirdly, the search was conducted only in the English language, hence publications in a different language may have been missed.

CONCLUSION

This systematic review hopes to contribute to updating the scientific literature published since 2016 regarding the professional integration of IQNs in Australia. Its findings reinforce previous publications in the area, but also add new evidence to the field. The importance of professional and cultural orientation programs for IQNs and the need to examine closely the training of locally qualified nurses in cultural competence are the two most significant findings to emerge from this study.

Further research is needed in order to understand barriers and facilitators better, depending on country of origin, clinical setting, or geographical location, and to understand how pathways and requirements for registration prepare IQNs to perform their work and to integrate into the Australian health care setting. It would also be helpful to understand colleagues' and society's views and expectations regarding the performance of IQNs in Australia. Moreover, this study points to the need to conduct further studies into discrimination and racism between colleagues, as a basis for strengthening the safety and quality of nursing care in Australia through the improved professional integration of IQNs into Australian healthcare settings.

IMPLICATIONS FOR RESEARCH, POLICY AND PRACTICE

This research study has the potential to be of interest to a variety of stakeholders in the healthcare industry, including policymakers, healthcare educators, healthcare workforce planners, and healthcare institutions. The findings of this study shed light on the complex and multifaceted issue of nurse migration, retention, and professional integration, particularly in high-income countries where the demand for healthcare professionals is high.

By analysing research on the experiences and perspectives IQNs who migrated to Australia, this review provides important insights into the challenges and opportunities that they face in their new work environments. In doing so, it highlights the need for healthcare organisations to create more inclusive workplaces that support the integration of IQNs into the local healthcare system. This study also serves as a call to address the persistence of discriminatory and racist practices in the Australian context. It underscores the importance of promoting cultural competency education among local nurses who work with IQNs, as this can help to mitigate potential misunderstandings and conflicts in the workplace. By fostering a more culturally competent workforce, healthcare organisations can create a more inclusive and supportive environment for all nurses, regardless of their background or country of origin.

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3.4 Conference and university presentations

This study was presented at two conferences:

- Correa-Betancour, M., Marcus, K., Balasubramanian, M., & Short, S. (2022). **Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: a mixed methods systematic review.** National Multicultural Health Conference 2023, Sydney, Australia, 21–22 November 2023.
- Correa-Betancour, M., Marcus, K., Balasubramanian, M., & Short, S. (2022). **Barriers and facilitators to the professional integration of internationally qualified nurses in Australia: a mixed methods systematic review.** Faculty of Medicine and Health, Higher Degree by Research Conference, The University of Sydney, 19–20 July 2023.

3.5 Literature review update since systematic review publication

3.5.1 Introduction

Given the significant global importance of the professional integration of IQNs, and particularly in the Australian context, this section presents and discusses studies published after the time frame of the systematic review (Correa-Betancour et al., 2024), in relation to the findings of the review.

3.5.2 Search strategy and time frame

The literature update followed the same search strategy outlined in the original systematic review, with the only modification being the time frame, which was adjusted to cover studies published between 2022 and October 2024.

3.5.3 Results

Since the publication of the systematic review, four articles meeting the inclusion criteria have been published (Kurup et al., 2023, 2024; Malik et al., 2024; Zhong et al., 2023). More detail of these studies can be found in Table 3.1. The findings from these studies are organised according to the themes identified in the original systematic review: individual factors and social factors. The theme of individual factors had two subthemes: a) psychological adaptation; and b) communication and language. The theme of social factors had three

subthemes: a) cultural differences in the nursing role; b) support, mentoring and appreciation; and c) discrimination and racism.

3.5.4 Summary of the new findings

Individual factors

Psychological adaptation

In terms of psychological adaptation, IQNs noted an increasing sense of authenticity, both in their career decisions and in how they expressed themselves in the workplace (Zhong et al., 2023). They also described becoming more open to individual differences, a shift that was largely shaped by their daily interactions within Australia's multicultural environment (Zhong et al., 2023).

Another form of psychological adjustment experienced by IQNs involved working in positions that did not make full use of their specialised skills (Kurup et al., 2024). Moving into roles outside their area of expertise often resulted in feelings of reduced competence, frustration and lower self-confidence. It could also lead to a sense of both professional and personal disconnection (Kurup et al., 2024). However, financial pressures frequently impacted the career choices of IQNs, compelling many nurses to take jobs outside their specialty (Kurup et al., 2024).

Communication and language

With regard to communication and language, IQNs faced varying degrees of frustration in adjusting to workplace communication in the local language, especially when it came to understanding colloquial expressions used by both nurses and patients (Zhong et al., 2023).

Social factors

Cultural differences in the nursing role

Two studies highlighted the differences that IQNs identified between nursing roles in their home countries and those in Australia (Kurup et al., 2024; Zhong et al., 2023). These differences include a wider range of employment opportunities, increased work flexibility, a higher degree of professional autonomy, and more freedom to express professional opinions in Australia. The most notable difference was the variety of employment options and greater

flexibility, which are highly valued as they allow nurses to broaden their experience, expand their scope of practice, hold multiple jobs or maintain a better work–life balance (Zhong et al., 2023).

Additionally, IQNs highlighted the advantages of being able to make independent judgements and autonomous decisions when working in Australia, contrasting this with the more passive nursing role in their home country, where nurses primarily follow doctors' instructions (Zhong et al., 2023). This situation differed significantly from their previous experiences, where the focus was on "maintaining harmony" and "avoiding disagreement". For some, this ability to express themselves authentically fostered a sense of fairness and equality in the workplace culture (Zhong et al., 2023).

Another difference identified by IQNs relates to the education and training Australian nurses receive compared to their own experiences. This includes differences in the curriculum structure, educational standards and duration of nursing programs. Additionally, IQNs noted a significant contrast in clinical experience, with their home countries offering more extensive and hands-on training, compared to what they perceived as limited clinical hours in Australia (Kurup et al., 2024).

In contrast, a key difference in the nursing role in Australia compared to their home country pertained to knowledge regarding voluntary assisted dying (VAD) (Malik et al., 2024). IQNs identified gaps in their understanding and emphasised the need for education and workplace training on VAD, particularly regarding its legal and ethical dimensions, their specific roles and how VAD intersects with their practice (Malik et al., 2024).

In three studies, IQNs highlighted differences in their scope of practice in Australia compared to their home countries, particularly in terms of authorised duties and responsibilities (Kurup et al., 2023, 2024; Zhong et al., 2023) and the demanding workload (Zhong et al., 2023). It was observed by IQNs that the restrictions on their scope of practice were substantial and often limiting, creating challenges in adapting to the Australian healthcare environment (Kurup et al., 2024). Many IQNs also expressed fear and uncertainty regarding their scope of practice in a new country, which was a significant source of stress and greatly impacted their overall experience in the Australian healthcare system (Kurup et al., 2024).

Support, mentoring and appreciation

In relation to this subtheme, two studies identified a disconnect between the advanced skills of IQNs and the limited recognition they receive during local recruitment processes (Kurup et al., 2023, 2024). These experiences highlight a significant gap in acknowledging and valuing the specialised skills and qualifications that IQNs possess, which hinders their ability to integrate effectively and raises concerns about their educational background and the transferability of their expertise within the Australian healthcare system (Kurup et al., 2024). For example, a cross-sectional study found that 45.5% of respondents were not employed in the nursing specialty they had trained for in their home country, as additional specialised training was required for such roles in Australia because their original specialisation was not recognised (Kurup et al., 2023).

The barriers to utilising specialist skills within the Australian healthcare system identified by participants included a lack of opportunities, cited as the primary obstacle (64.4%), followed by the absence of transition pathways (59.3%) and financial instability (57.6%) (Kurup et al., 2023). Additionally, these challenges not only hinder IQNs in applying their current skills, but also in progressing their careers within the Australian healthcare system (Kurup et al., 2024). Several participants in two studies noted that recruitment managers often lacked a comprehensive understanding of IQNs' qualifications and were more focused on filling immediate vacancies than on leveraging the valuable expertise these nurses brought with them (Kurup et al., 2023, 2024).

Support was identified as a key facilitator in helping IQNs successfully transition into their specialised roles within the Australian healthcare system. This support could come from colleagues, managers or the broader social network. In particular, support from international nurses with previous immigration experience was highly appreciated, highlighting the essential role peers with similar backgrounds play in easing the transition by offering guidance and encouragement (Kurup et al., 2024). Additionally, managerial support was recognised as crucial in overcoming challenges associated with unrecognised skill sets (Kurup et al., 2024). IQNs expressed frustration over the absence of support that could have aided them in integrating their expertise into the local healthcare system. This sentiment reflects feelings of abandonment and a perceived lack of structured support to help IQNs fully utilise their skills (Kurup et al., 2024).

Discrimination and racism

IQNs reported difficulties in forming social connections with colleagues, consistently describing their relationships as “simple but distant” (Zhong et al., 2023). Discrimination in the workplace was also a significant issue identified by IQNs, which included unequal treatment or denial of opportunities based on characteristics such as race, gender or disability (Kurup et al., 2024). Experiences of discrimination, racism or nepotism from colleagues, which limited the ability of IQNs to utilise their specialised skills fully, were also mentioned (Kurup et al., 2024). Additionally, IQNs recognised a prevailing negative bias against nurses from third-world countries, regardless of their qualifications or competence (Kurup et al., 2024). The extent of these experiences varied across different workplaces (Kurup et al., 2024).

Table 3.1. Literature review update since systematic review publication: summary of included studies, by date of publication

First author and year	Aim or objectives	Study type	Methodology	Sample size	Sample characteristics	Setting	Location	Main findings
Kurup, C. et al. (2023)	To explore the challenges and enablers of transferring specialised skills for internationally qualified nurses (IQNs) in Australia from the nurses' viewpoint	Cross-sectional study	STROBE checklist	71 IQNs	71 IQNs registered to work in Australia, employed within a healthcare setting, and holding specialised skills acquired in their home country	Online survey	Australia	Survey results identified facilitators such as competence, scope of practice, language proficiency and an understanding of decision-making, while barriers included a lack of opportunities, insufficient transition pathways, doubts about overseas education and financial instability. Addressing these barriers and facilitators, along with creating tailored transition pathways, is essential for optimising the utilisation of specialised skills among IQNs in Australia.

First author and year	Aim or objectives	Study type	Methodology	Sample size	Sample characteristics	Setting	Location	Main findings
Zhong et al. (2023)	To explore how Chinese migrant nurses adjust and develop professionally while building their nursing careers in Australia	Qualitative descriptive approach	Narrative inquiry	17 Chinese-qualified nurses	17 IQNs who obtained their initial nursing qualification in mainland China, were registered to work in Australia, and had between 1 and 10 years of work experience in the country	Face-to-face or online interview	Australia	Three main themes and eight subthemes emerged from the findings. Perceived differences in nursing included work options and flexibility, professional autonomy, and the freedom to express professional opinions. Challenges to adaptation were related to communication barriers, nursing workload and responsibilities, and relationships with colleagues. Participants' professional transition experiences were marked by two significant areas of personal growth: embracing their authentic selves and accepting individual differences.

First author and year	Aim or objectives	Study type	Methodology	Sample size	Sample characteristics	Setting	Location	Main findings
Kurup, C. et al. (2024)	To investigate IQNs' perspectives on the enablers and obstacles to transferring their specialised skills in Australia	Descriptive research design with a cross-sectional survey	A self-designed survey, which included six open-ended questions analysed through thematic content analysis, conducted using snowball sampling	Sixty-three IQNs	63 IQNs who had acquired specialised skills in their home country, were registered with the Australian Health Practitioner Regulation Agency, and had been employed in an Australian healthcare setting for at least 1 year.	Survey with open-ended questions	Australia	For transferring specialised skills in Australia, the findings highlighted facilitators such as support, prior experience and self-agency, alongside barriers such as systemic obstacles, bias/discrimination, feeling undervalued and a lack of trust in the skill transition process. It is argued that recognising and addressing these facilitators and barriers, coupled with the development of customised pathways for skill integration, is essential for optimising the effective utilisation of IQNs' expertise.

First author and year	Aim or objectives	Study type	Methodology	Sample size	Sample characteristics	Setting	Location	Main findings
Malik et al. (2024)	To examine the knowledge and attitudes of nurses from culturally and linguistically diverse (CALD) backgrounds regarding voluntary assisted dying (VAD), and to identify strategies that support their readiness and preparation for exposure to VAD	Qualitative descriptive approach	This study employed purposive and snowball sampling methods. Data collection involved one focus group and 16 in-depth interviews, with thematic analysis used to interpret the findings	21 nurses from CALD backgrounds	Nurses from CALD backgrounds with experience in caring for terminally ill patients	Semi-structured individual interviews in person or by phone and a focus group	Victoria, Australia	Nurses highlighted gaps in their knowledge and emphasised the need for education and workplace training on VAD, particularly its legal and ethical dimensions, clarity around their roles, communication techniques, and how VAD integrates into their practice. They also identified teaching strategies that could help prepare them to work safely and confidently in clinical settings where VAD is an option for patients.

3.5.5 Discussion and comparison with original review

These newly identified articles offer fresh insights into the professional integration of IQNs in Australia. Regarding psychological adaptation, they reaffirmed the importance of being able to express oneself at work, while introducing two additional factors: the need to adapt to career decisions, and the frustration experienced when unable to perform one's desired role. These situations are consistent with the acculturative stress that migrants usually face in their adaptation to a new country (Berry & Annis, 1974; Ward et al., 2021).

In terms of communication and language, the findings support those of the original systematic review, particularly highlighting the challenges that the use of slang poses to IQNs' ability to communicate effectively (Correa-Betancour et al., 2024).

The second theme was focused on identifying social factors that may act as barriers and facilitators to the professional integration of IQNs. Regarding cultural differences in the nursing role, these studies provide additional insights on the broader range of employment opportunities and increased work flexibility available in Australia (Kurup et al., 2024; Zhong et al., 2023). However, they contradict the findings of the systematic review regarding the higher degree of professional autonomy. It is important to note that the study reporting greater professional autonomy involved participants from only one country, which could explain this discrepancy (Zhong et al., 2023). However, the findings related to greater freedom in expressing professional opinions align with those of the original systematic review (Correa-Betancour et al., 2024).

Additionally, one study highlighted differences in education and training between Australian nurses and those from other countries (Kurup et al., 2024). Participants noted that education in their home countries appeared to be more comprehensive and extensive (Kurup et al., 2024). However, another study identified gaps in knowledge and training in areas such as VAD, which is neither common nor legal in many countries and, therefore, may not be included in nursing curricula elsewhere (Malik et al., 2024). These findings are consistent with the original systematic review, where differences in the nursing role in Australia regarding patients' and families' expectations, the approach to end-of-life care and medication and pain management of patients were identified (Correa-Betancour et al., 2024; O'Callaghan et al., 2018).

Another distinction in the nursing role identified by IQNs in these studies was the difference in the scope of practice, which involved greater responsibilities, increased workload and more restrictions in Australia compared to their roles in their home countries (Kurup et al., 2023, 2024; Zhong et al., 2023). The findings that are consistent with those reported in the original systematic review were differences in legal and professional responsibilities, and the scope of practice (Correa-Betancour et al., 2024; O'Callaghan et al., 2018).

In terms of support, mentoring and appreciation, the findings in these studies reinforce those of the original systematic review, particularly by acknowledging the lack of recognition and appreciation for previous experience and specialties in Australia.

The final subtheme is discrimination and racism. The findings from these studies reaffirm what was highlighted in the original systematic review, particularly the persistence of workplace discrimination as a major barrier to professional integration of IQNs (Correa-Betancour et al., 2024). This includes unequal treatment, or the denial of opportunities based on race, gender or disability (Kurup et al., 2024). The original systematic review also identified evidence of accent discrimination in multicultural work environments where diverse languages are spoken (de Souza et al., 2016), with specific examples documented in New South Wales healthcare settings (New South Wales Nurses and Midwives' Association, 2019).

Additionally, the studies highlight the ongoing challenges IQNs face in forming social connections with colleagues. This finding aligns with the results of the original systematic review, which revealed that workplace acculturation is uncommon, and the integration of IQNs is often perceived as solely their responsibility, rather than a mutual process (Correa-Betancour et al., 2024). One study provided new insights into the negative bias faced by nurses from third-world countries, regardless of their qualifications or competence (Kurup et al., 2024). This aligns with the findings of the original systematic review, which identified limited recognition of the valuable contributions that IQNs offer to the workplace, particularly due to their diverse experiences and skills (Correa-Betancour et al., 2024).

3.5.6 Conclusion

The findings from these four new studies reinforce those of the original systematic review and provide additional insights into the previously identified themes. While there are facilitators that support the professional integration of IQNs, significant barriers remain. Identifying these facilitators and barriers is crucial for enhancing IQNs' integration and fostering team cohesion, especially in a country like Australia where multicultural healthcare teams are common.

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Chapter Appendices

Appendix 1

PRISMA 2020 checklist

TITLE			
Title	1	Identify the report as a systematic review.	Page 1 (separated file)
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Page 1
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Page 4- 7
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	Page 8
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Page 8
Informatio n sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Page 9
Search strategy	7	Present the full search strategies for all databases, registers, and websites, including any filters and limits used.	Page 9 and appendix 2
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including	Page 9

		how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	

Section and Topic	**Item #**	**Checklist item**	**Location where item is reported**
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Page 9
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	Appendix 6
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	Appendix 6
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	Page 10

Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean	Page 11

		difference) used in the synthesis or presentation of results.	
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Page 10
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Page 10
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Page 10
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Page 10
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta- regression).	10
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	Page 10

Reporting bias assessme nt	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	Page 10
Certainty assessme nt	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	Page 10
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Page 11
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Appendix 4
Study characteri stics	17	Cite each included study and present its characteristics.	Pages 13 - 15
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	10
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Pages 13 to 15 and appendix 6
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Page 9 in quality appraisal score and appendix 5

	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	No statistical syntheses were conducted
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	Page 10
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	Page 10
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	There were no missing results reported in the studies
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	Page 9
DISCUSSION			
Discussio n	23a	Provide a general interpretation of the results in the context of other evidence.	Pages 22 to 26
	23b	Discuss any limitations of the evidence included in the review.	Page 26
	23c	Discuss any limitations of the review processes used.	26
	23d	Discuss implications of the results for practice, policy, and future research.	Page 27

Section and Topic	Item #	Checklist item	Location where item is reported
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	page 8
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	Page 8
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	No amendments were made
Support	25	Describe sources of financial or non- financial support for the review, and the role of the funders or sponsors in the review.	Page 1 (separated file)
Competing interests	26	Declare any competing interests of review authors.	Page 1
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	Provided in the supplementary data

Appendix 2

Search strategy, that was constructed using the scheme Population, Phenomenon of Interest, Context and Setting Search strategy

Population		***Phenomenon of interest***		***Context***		***Setting***
"*international* * trained *nurs*"* OR 'internationall y qualified nurs *' OR "overseas trained *nurs **" OR "*foreign educ ated nurs**" OR "*migran* nur**"	*AND*	*integration** OR *adaptation** OR *adjustment** OR *transition** OR *experienc** OR "*job satisfact ion**" OR "*career aspir ation**" OR *retention** OR *discriminatio n**	AND	Barriers Facilitato rs	*AND*	*Australia** OR *Queensland* OR Victoria OR "S*outh Australia"* OR N*orthern Territory"* OR Tasmania OR "*Western Australia*" OR "New South Wales" OR "Australian Capital Territory"

The search was run using the following structure and including article title, abstract and key words:

1. (“*international** trained *nurs**” OR “internationally qualified nurs*” OR “overseas trained *nurs**” OR “*foreign educated nurs**” OR “*migran* nur**”)

AND

2. *(integration** OR *adaptation** OR *adjustment** OR *transition** OR *experienc** OR “*job satisfaction**” OR “*career aspiration**” OR *retention** OR *discriminatio n**)

AND

1. *(Australia** OR *Queensland* OR Victoria OR

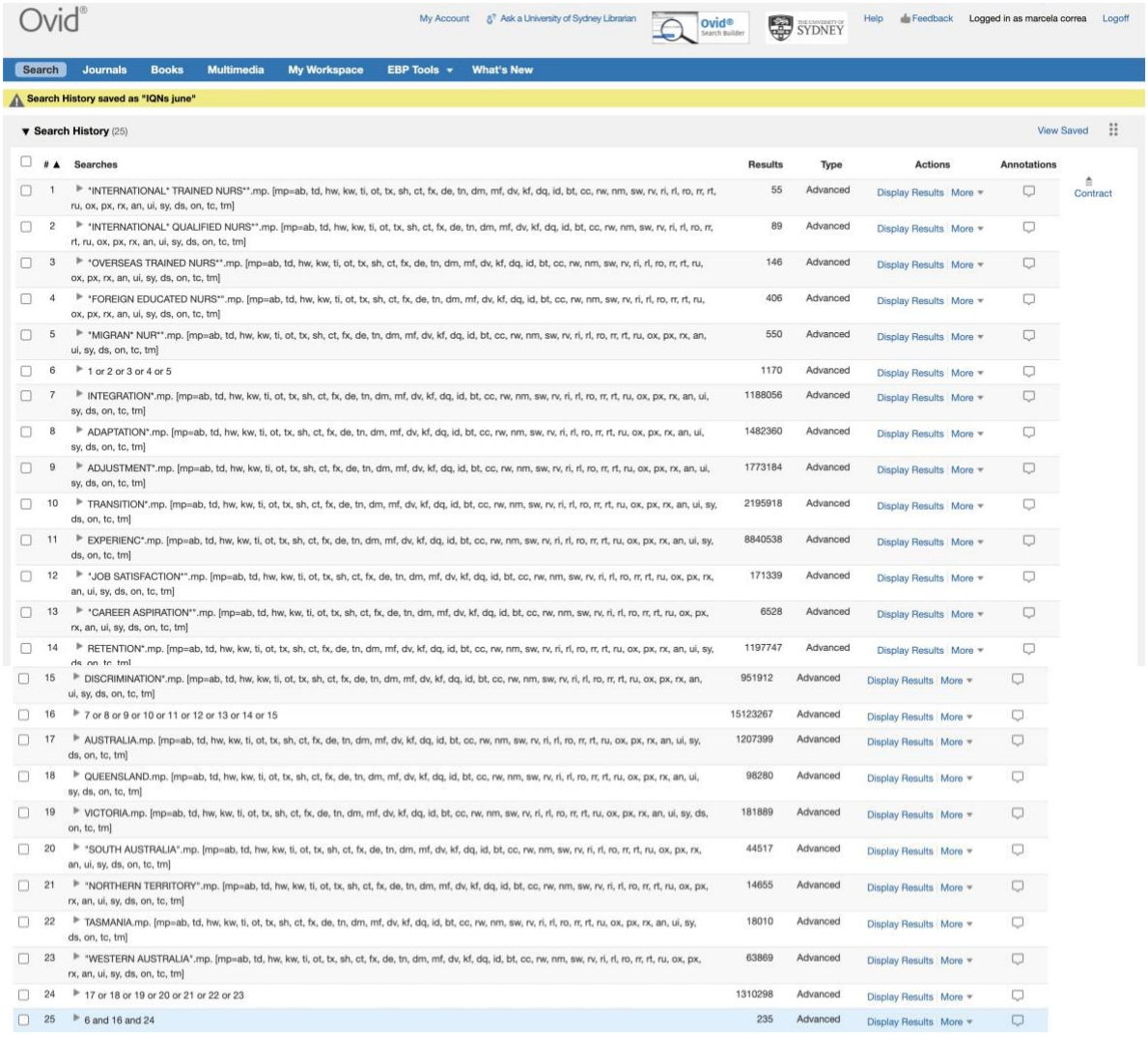
   “S*outh Australia”* OR N*orthern Territory”* OR Tasmania

   OR “*Western Australia*” OR “New South Wales” OR “Australian Capital Territory”)

Appendix 3

Search outcome tables retrieve on June 6th, 2022, from OVID database

#	Query	Results from 6 Jun 2022
1	"INTERNATIONAL* TRAINED NURS*".mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	55
2	"INTERNATIONAL* QUALIFIED NURS*".mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	89
3	"OVERSEAS TRAINED NURS*".mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	146
4	"FOREIGN EDUCATED NURS*".mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	406
5	"MIGRAN* NUR*".mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	550
6	1 or 2 or 3 or 4 or 5	1,170
7	INTEGRATION*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	1,188,056
8	ADAPTATION*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	1,482,360
9	ADJUSTMENT*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	1,773,184
10	TRANSITION*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	2,195,918
11	EXPERIENC*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	8,840,538
12	"JOB SATISFACTION*".mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	171,339
13	"CAREER ASPIRATION*".mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	6,528
14	RETENTION*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	1,197,747
15	DISCRIMINATION*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	951,912
16	7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15	15,123,267
17	AUSTRALIA.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	1,207,399
18	QUEENSLAND.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	98,280
19	VICTORIA.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	181,889
20	"SOUTH AUSTRALIA".mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	44,517
21	"NORTHERN TERRITORY".mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	14,655
22	TASMANIA.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	18,010
23	"WESTERN AUSTRALIA".mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm]	63,869
24	17 or 18 or 19 or 20 or 21 or 22 or 23	1,310,298
25	6 and 16 and 24	235


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What's New
Search History saved as "IQNs june"
▼ Search History (25)
View Saved
Contract
▲ Searches Results Type Actions Annotations
1 *INTERNATIONAL* TRAINED NURS**.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 55 Advanced Display Results | More
2 *INTERNATIONAL* QUALIFIED NURS**.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 89 Advanced Display Results | More
3 *OVERSEAS TRAINED NURS**.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 146 Advanced Display Results | More
4 *FOREIGN EDUCATED NURS**.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 406 Advanced Display Results | More
5 *MIGRAN* NUR**.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 550 Advanced Display Results | More
6 1 or 2 or 3 or 4 or 5 1170 Advanced Display Results | More
7 INTEGRATION*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 1188056 Advanced Display Results | More
8 ADAPTATION*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 1482360 Advanced Display Results | More
9 ADJUSTMENT*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 1773184 Advanced Display Results | More
10 TRANSITION*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 2195918 Advanced Display Results | More
11 EXPERIENC*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 8840538 Advanced Display Results | More
12 *JOB SATISFACTION**.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 171339 Advanced Display Results | More
13 *CAREER ASPIRATION**.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 6528 Advanced Display Results | More
14 RETENTION*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 1197747 Advanced Display Results | More
15 DISCRIMINATION*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 951912 Advanced Display Results | More
16 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 15123267 Advanced Display Results | More
17 AUSTRALIA.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 1207399 Advanced Display Results | More
18 QUEENSLAND.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 98280 Advanced Display Results | More
19 VICTORIA.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 181889 Advanced Display Results | More
20 *SOUTH AUSTRALIA*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 44517 Advanced Display Results | More
21 *NORTHERN TERRITORY*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 14655 Advanced Display Results | More
22 TASMANIA.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 18010 Advanced Display Results | More
23 *WESTERN AUSTRALIA*.mp. [mp=ab, td, hw, kw, ti, ot, tx, sh, ct, fx, de, tn, dm, mf, dv, kf, dq, id, bt, cc, rw, nm, sw, rv, ri, rl, ro, rr, rt, ru, ox, px, rx, an, ui, sy, ds, on, tc, tm] 63869 Advanced Display Results | More
24 17 or 18 or 19 or 20 or 21 or 22 or 23 1310298 Advanced Display Results | More
25 6 and 16 and 24 235 Advanced Display Results | More

Appendix 4

List of studies not selected and the reason for their exclusion

	Title by alphabetical order	**Reason for exclusion**
1	A 15-Year Trend Study of Internationally Educated Nurses' NCLEX-RN Performance. Montegrico, James/ 2021;42(1):22-28 DOI: 10.1097/01.NEP.0000000000000660 Ref ID: 00024776- 202101000-00006	Not congruent with review objectives.
2	A courageous journey: Experiences of migrant Philippine nurses in Norway. Nortvedt, Line; RN, PhD; Lohne, Vibeke; Dahl, Kari / 2020;29(3-4):468-479 DOI: 10.1111/jocn.15107 · Ref ID: 00019038-202002000-00016	Not congruent with review objectives.
3	A job with broad horizons. Pearce, Lynne Nursing Standard 01/10/ 2018;32(20):38-39 RCNi 2018 01/10/ DOI: 10.7748/ns.32.20.38.s31 · Ref ID: 127264558	Not congruent with review objectives.
4	A new job in a new country. Barron, Vasil Nursing Standard 11/23/ 2016;31(13):36-37 DOI: 10.7748/ns.31.13.36.s41 Ref ID: 119639933	Not congruent with review objectives.
5	A survey of strategies for increasing the number of medical learners in all Tasmanian general practices Radford, J Focus on Health Professional Education 2017;18(2):76-89 2017	Not congruent with review objectives.
6	ACMHN's 42nd International Mental Health Nursing Conference Nurses striving to tackle disparity in health care 25 - 27 October 2016 Adelaide Convention Centre. / 2016;25(101140527):3-53 DOI: 10.1111/inm.12771 · Ref ID: 00134462-201610001-00002	Not congruent with review objectives.
7	Ageing in the nursing workforce - a global challenge in an Irish context. Ryan, C.; MSc, BA; PhD Scholar, Lecturer; Bergin, M.; RN, PhD; MMedSc, BSc; White, M.; MBS, MSc; Wells, J.S.G.; MSc, BA International Nursing Review/ 2019;66(2):157-164	Not congruent with review objectives.

	DOI: 10.1111/inr.12482 · Ref ID: 00004396-201905000-00005	

8	An investigation into the relationships between bullying, discrimination, burnout and patient safety in nurses and midwives: is burnout a mediator?. Johnson, Judith; Mitchinson, Lucy; Parmar, Mayur; Opio-te, Gail; Louch, Gemma; Grange, Angela / 2019;24(8):604-619 DOI: 10.1177/1744987119880329 · Ref ID: 01246240-201912000-00008	Not congruent with review objectives.
9	Applying heuristic inquiry to nurse migration from the UK to Australia Vafeas, C; Hendricks, J NURSE RESEARCHER 2017;24(3):13-18 2017 DOI: 10.7748/nr.2017.e1475	Not congruent with inclusion criteria.
10	Can China lure its Foreign-trained-nurses home or will Australia win the nursing talent war? Wang, Carol Chunfeng Australian Nursing and Midwifery Journal 2017;25(1):38 2017	Not congruent with review objectives.
11	Can the unemployed be trained to care for the elderly? The effects of subsidized training in elderly care. Dauth, Christine; Lang, Julia Health Economics / 2019;28(4):543-555 DOI: 10.1002/hec.3863 · Ref ID: 01445427-201904000-00008	Not congruent with review objectives.
12	Challenges and experiences of overseas qualified nurses adjusting to new roles and health care systems: A narrative review of the literature. Zanjani, Maya Ebrahimi; Ziaian, Tahereh; Ullrich, Sandra Singapore Nursing Journal 05//May-Aug2018 2018;45(2):7-16 Ref ID: 133277968	Not congruent with inclusion criteria.
13	Challenges and opportunities for the multicultural aged care workforce: A systematic review and meta-synthesis. Chen, Li; RN, BN; Xiao, Lily; Han, Weifeng; Meyer, Claudia; PhD, MPH; Research Fellow, Adjunct; Muller, Amanda / 2020;28(6):1155-1165 DOI: 10.1111/jonm.13067 · Ref ID: 00019040-202009000-00003	Not congruent with review objectives.

14	Challenges, coping responses and supportive interventions for international and migrant students in academic nursing programs in major host countries: a scoping review with a gender lens. Merry, Lisa; Vissandjee, Bilkis; Verville-Provencher, Kathryn BMC nursing / 2021;20(1):174 DOI: 10.1186/s12912-021-00678-0 · Ref ID: 34537039	Not congruent with inclusion criteria.
15	Challenges faced by international nurses when migrating: an integrative literature review. Pung, L.X.; Goh, Y.S.; MN, PhD International Nursing Review / 2017;64(1):146-165 DOI: 10.1111/inr.12306 · Ref ID: 00004396-201701000-00020	Not congruent with inclusion criteria.
16	Challenging the ethnic pyramid: Golden rules and organisational measures towards a more inclusive work environment Munkejord, Mai / 2019;27(7):1522-1529 DOI: 10.1111/jonm.12838 Ref ID: 00019040-201910000-00025	Not congruent with review objectives.
17	Community assets and capabilities to recruit and retain GPs: The Community Apgar Questionnaire in rural Victoria Terry, DR; Baker, E; Schmitz, DF Rural and Remote Health 2016;16(4):1-10	Not congruent with review objectives.
18	Coronavirus disease 2019 critical care essentials course for nurses: Development and implementation of an education program for healthcare professionals Jarden, Rebecca; Scanlon, Andrew; Bridge, Nicholas; McKeever, Stephen; Turner, Rosemary; Prescott, Hollie; Thompson, John; Cambridge, Prue; Kinney, Sharon; Leong, Nicholas; Gerdtz, Marie The Australian Journal of Advanced Nursing 2021;39(1):34-43	Not congruent with review objectives.
19	Cultural diversity in the Australian early childhood education workforce: What do we know, what don't we know and why is it important?. Gide, Sene; Wong, Sandie; Press, Frances; Davis, Belinda / 2022;47(1):48-61 DOI: 10.1177/18369391211057292 · Ref ID: 01516395-202247010-00005	Not congruent with review objectives.

20	Cultural immersion through international experiences among Japanese nurses: Present status, future intentions, and perceived barriers. Chiba, Yoko; Nakayama, Takeo / 2016;13(3):378-390 DOI: 10.1111/jjns.12120 · Ref ID: 01238568-201607000-00008	Not congruent with review objectives.
21	Current Data of Foreign-Educated Nurses in Italy and the Recognition of Their Professional Qualifications. Caruso, Rosario; PhD, RN; Rocco, Gennaro; Shaffer, Franklin; EdD, RN; Stievano, Alessandro Nursing Administration Quarterly / 2019;43(1):26-31 DOI: 10.1097/NAQ.0000000000000325 · Ref ID: 00006216-201901000- 00007	Not congruent with review objectives.
22	Dealing with uncertain results from chromosomal microarray and exome sequencing in the prenatal setting: An international cross-sectional study with healthcare professionals. Lewis, Celine; Hammond, Jennifer; Klapwijk, Jasmijn E.; Harding, Eleanor; Lou, Stina; Vogel, Ida; Szepe, Emma J.; Hui, Lisa; Ingvoldstad- Malmgren, Charlotta; Soller, Maria J.; Ormond, Kelly E.; Choolani, Mahesh; Hill, Melissa; Riedijk, Sam; Szepe, Emma Jane; Ingvoldstad- Malmgren, Charlotta; Soller, Maria Johansson Prenatal Diagnosis 05// 2021;41(6):720-732 DOI: 10.1002/pd.5932 · Ref ID: 150340423	Not congruent with review objectives.
23	Developing nurses' intercultural/intraprofessional communication skills using the EXCELLence in Cultural Experiential Learning and Leadership Social Interaction Maps. Henderson, Saras; BAppSc, MEd; Barker, Michelle; SocWk, MSW / 2018;27(17-18):3276-3286 DOI: 10.1111/jocn.14089 · Ref ID: 00019038-201809000-00006	Not congruent with review objectives.
24	Early nurse attrition in New Zealand and associated policy implications. Walker, L.; Senior Lecturer, Adjunct; Clendon, J.; RN, PhD / 2018;65(1):33-40 DOI: 10.1111/inr.12411 Ref ID: 00004396-201802000-00009	Not congruent with review objectives.

25	Educating for interprofessional practice: Moving from knowing to being, is it the final piece of the puzzle? Ward, Helena; Gum, Lyn; Attrill, Stacie; Bramwell, Donald; Lindemann, Iris; Lawn, Sharon; Sweet, Linda Day Surgery Australia 2018;17(1):10-17	Not congruent with review objectives.
26	Engaging mothers: Breastfeeding experiences recounted (EMBER). A pilot study. Prendergast, Ellen; James, Jennifer Breastfeeding Review 2016;24(2):11-19 2016	Not congruent with review objectives.
27	Enhancing health professional education capacity in the Western Pacific region Sweet, Linda; Young, Louise; Kado, Sinead Rural and Remote Health 2018;18(3):[274]-[279] DOI: 10.22605/RRH4306	Not congruent with review objectives.
28	Evaluation of a digital application to support internationally qualified nurses' communication and leadership skills Aggar C.; Shinners L.; Penman O.; Mainey L.; Kurup C.; Hallett J.; Doran F.; Raddi S. Nurse education today / 2021;104 DOI: 10.1016/j.nedt.2021.104982 · Ref ID: 635569006	Not congruent with review objectives.
29	Evaluation of an international educational programme for health care professionals on best practice in the management of a perinatal death: IMproving Perinatal mortality Review and Outcomes Via Education (IMPROVE). Gardiner, Paul A; Kent, Alison L; Rodriguez, Viviana; Wojcieszek, Aleena M; Ellwood, David; Gordon, Adrienne; Wilson, Patricia A; Bond, Diana M; Charles, Adrian; Arbuckle, Susan; Gardener, Glenn J; Oats, Jeremy J; Erwich, Jan Jaap; Korteweg, Fleurisca J; Duc, T H Nguyen; Leisher, Susannah Hopkins; Kishore, Kamal; Silver, Robert M; Heazell, Alexander E; Storey, Claire BMC Pregnancy & Childbirth 11/25/ 2016;16():376-376 DOI: 10.1186/s12884-016-1173-8 · Ref ID: 119803485	Not congruent with review objectives.
30	Experiences of internationally qualified midwives and nurses in Australia and other developed nations: a structured literature review, Javanmard M; Steen M; Vernon R; et al Evidence Based Midwifery 011 2017;15(3):95-100 2017 011 Ref ID: 2017101152	Not congruent with inclusion criteria.

31	Experiences of New Zealand registered nurses of Chinese ethnicity during the COVID-19 pandemic. Song, Jenny; McDonald, Christine / 2021;30(5-6):757-764 DOI: 10.1111/jocn.15607 · Ref ID: 00019038-202103000-00015	Not congruent with review objectives.
32	Experiences of Nigerian Internationally Educated Nurses Transitioning to United States Health Care Settings. Iheduru-Anderson, Kechinyere; DNP, RN; CNE, CWCN; Wahi, Monika; MPH, CPH / 2018;29(6):603-610 DOI: 10.1177/1043659618766225 · Ref ID: 00002045-201811000-00014	Not congruent with review objectives.
33	Experiences of registered nurses from a refugee background: A scoping review. Ng Chok, Harrison; MPH, BSc; Mannix, Judy; PhD, MNurs; Dickson, Cathy; PhD, DN; MCN, BHlthSc; Wilkes, Lesley; PhD, MHPEd; GDipEd Nurs, BSc Journal of Clinical Nursing / 2018;27(7-8):e1275-e1283 DOI: 10.1111/jocn.14257 · Ref ID: 00019038-201804000-00043	Not congruent with review objectives.
34	Exploring longitudinal shifts in international nurse migration to the United States between 2003 and 2013 through a random effects panel data analysis. Squires, A; Ojemeni, MT; Jones, S Human Resources For Health 2016;14(): 2016 DOI: 10.1186/s12960-016-0118-7	Not congruent with review objectives.
35	Exploring the experiences of internationally and locally qualified nurses working in a culturally diverse environment Australian Journal of Advanced Nursing / 2018;36(2):23-34 Australia Australian Nursing Federation (E-mail: ajan@anmf.org.au) 2018	Not congruent with review objectives.
36	Factors that influence Australian early career nurse employment outcomes and settings: A prospective cohort study. Cottle-Quinn, Amanda; RN, MHPrac; Tower, Marion; RN, PhD; Eley, Rob; BSc Hons, MSc / 2021;29(3):459-467 DOI: 10.1111/jonm.13166 · Ref ID: 00019040-202104000-00013	Not congruent with review objectives.

37	Foreign educated nurses' work experiences and patient safety-A systematic review of qualitative studies Viken, B; Solum, EM; Lyberg, A Nursing Open 2018;5(4):455-468 2018 DOI: 10.1002/nop2.146	Not congruent with inclusion criteria.
38	Global migration and factors that support acculturation and retention of international nurses: A systematic review Pressley C.; Newton D.; Garside J.; Simkhada P.; Simkhada B. International Journal of Nursing Studies Advances / 2022;4 DOI: 10.1016/j.ijnsa.2022.100083 · Ref ID: 2019102817	Not congruent with review objectives.
39	Global nursing and the lived experience of migration intermediaries. van den Broek, Diane; Groutsis, Dimitria Work, Employment and Society / 2017;31(5):851-860 US Sage Publications US 2017 / DOI: 10.1177/0950017016658437https://dx.doi.org/10.1177/0950017016658437 58437 · Ref ID: 2017-42238-008	Not congruent with review objectives.
40	Going up, going down: The experience, control and management of gestational diabetes mellitus among Southeast Asian migrant women living in urban Australia Jirojwong, Sansnee; Brownhill, Suzanne; Dahlen, Hannah G; Johnson, Maree; Schmied, Virginia. Health Promotion Journal of Australia 2017;28(2):123-131 2017	Not congruent with review objectives.
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42	Hand hygiene: Attitudes and practices of nurses, a comparison between 2007 and 2015. Kingston, Liz; Slevin, Barbara; O'Connell, Nuala; MB, MSc; MD, FRCPath; Dunne, Colum; PhD, MBA / 2017;45(12):1300-1307 DOI: 10.1016/j.ajic.2017.08.040 · Ref ID: 00000545-201712000-00003	Not congruent with review objectives.

43	Home and away: A national mixed-methods questionnaire survey of host and migrant Registered Nurses in New Zealand Brunton, M; Cook, C; Walker, L; Clendon, J; Atefi, N Collegian 2020;27(2):164-173 2020 DOI: 10.1016/j.colegn.2019.08.004	Not congruent with review objectives.
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45	Hospital-acquired pressure injury prevention in people with a BMI of 30.0 or higher: A scoping review protocol Marshall, Victoria; Team, Victoria; Weller, Carolina Wound Practice & Research: Journal of the Australian Wound Management Association 2021;29(3):133-139 2021	Not congruent with review objectives.
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47	Infection prevention and control practices in the deployed military field hospital: An integrative review Skipp, J; Zimmerman, P; van de Mortel, T Journal of Military and Veterans' Health 2020;28(2):57-69 2020	Not congruent with review objectives.
48	Integration of advanced practice providers into the Israeli healthcare system Aaron, EM; Andrews, CS Israel Journal Of Health Policy Research 2016;5: 2016 DOI:10.1186/s13584-016-0065-8	Not congruent with review objectives.

49	Intention to migrate among the next generation of Turkish nurses and drivers of migration. Oncu, Emine; soglu, Sumbule; Karadag, Gulendam; Alacam, Burcu; Gov, P; Selcuk Tosun, Alime; Sahin Orak, Nuray; ker, Asl / 2021;29(3):487-496 2021 / DOI: 10.1111/jonm.13187 · Ref ID: 00019040-202104000-00016	Not congruent with review objectives.

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51	Internationally qualified nurse communication-A qualitative cross country study. Brunton, Margaret; RN, PhD; Cook, Catherine; Kuzemski, Dawn; Brownie, Sharon; Thirlwall, Alison Journal of Clinical Nursing / 2019;28(19-20):3669-3679 DOI: 10.1111/jocn.14968 · Ref ID: 00019038-201910000-00032	Not congruent with review objectives.
52	Internationally qualified nurses' perceptions of the competencies that pertain to patient safety Kane A.; Tait C.; Arcus K. Nurse education in practice / 2019;38 DOI: 10.1016/j.nepr.2019.06.001 · Ref ID: 628545535	Not congruent with review objectives.
53	Intersectionality and Critical Realism: A Philosophical Framework for Advancing Nursing Leadership. Aspinall, Cathleen; MSc, RN; Jacobs, Stephen; Frey, Rosemary Advances in Nursing Science / 2019;42(4):289-296 DOI: 10.1097/ANS.0000000000000275 · Ref ID: 00012272-201910000- 00003	Not congruent with review objectives.

54	Investigating the Impacts of Acculturation Stress on Migrant Care Workers in Australian Residential Aged Care Facilities. Adebayo, Bola; MPH, BDS; Nichols, Pam; PhD, BSc; Albrecht, Matthew; PhD, BSc; Brijnath, Bianca; Heslop, Karen; Journal of Transcultural Nursing 2021;32(4):389-398 DOI: 10.1177/1043659620947810 · Ref ID: 00002045-202132040-00011	Not congruent with review objectives.

55	Learning to accept incontinence and continence care in residential aged care facilities: Family members' experiences Ostaszkiewicz, Joan; Tomlinson, Emily; Hutchinson, Alison The Australian and New Zealand Continence Journal 2016;22(3):66-73 2016	Not congruent with review objectives.
56	Life in the pandemic: Some reflections on nursing in the context of COVID-19. Jackson, Debra; Bradbury-Jones, Caroline; Baptiste, Diana; Gelling, Leslie; Morin, Karen; Neville, Stephen; Smith, Graeme Journal of Clinical Nursing/ 2020;29(13-14):2041-2043 DOI: 10.1111/jocn.15257 · Ref ID: 00019038-202007000-00002	Not congruent with review objectives.
57	Migration Experiences of Foreign Educated Nurses: A Systematic Review of the Literature. Moyce, Sally; Lash, Rebecca; de Leon Siantz, Mary Journal of Transcultural Nursing / 2016;27(2):181-188 DOI: 10.1177/1043659615569538 · Ref ID: 00002045-201603000-00012	Not congruent with inclusion criteria.
58	Migration motives and integration of international human resources of health in the United Kingdom: systematic review and meta-synthesis of qualitative studies using framework analysis Davda, Latha S; Gallagher, Jennifer E; Radford, David R Human Resources for Health 2018;16 DOI: 10.1186/s129600180293-9	Not congruent with review objectives.
59	Milestones in the journey: The story of refugees becoming registered nurses in Australia. Ng Chok, Harrison; Lewis, Peter; Mannix, Judy; Dickson, Cathy; Wilkes, Lesley/ Journal of Advanced Nursing 2021;77(11):4525-4536 DOI: 10.1111/jan.14971 · Ref ID: 00004471-202111000-00019	Not congruent with review objectives.

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62	My Questionable Status as a Friendly Enemy Alien: British Responses to Jewish Refugee Nurses 1933 to 1948. Brooks, Jane; PhD, RN/ 2021;29(1):202-222 / DOI: 10.1891/1062-8061.29.202 · Ref ID: 00008523-202129010-00011	Not congruent with review objectives.
63	Nativity status and workplace discrimination in registered nurses: Testing the mediating role of psychosocial work characteristics. Wesolowska, Karolina; Elovainio, Marko; Komulainen, Kaisla; Hietapakka, Laura; Heponiemi, Tarja / 2020;76(7):1594-1602 DOI: 10.1111/jan.14361 · Ref ID: 00004471-202007000-00015	Not congruent with review objectives.
64	New collaborative initiative to improve access to healthcare for migrant and refugee women Abbasova, Gulnara Australian Nursing and Midwifery Journal 2017;25(4):41 2017	Not congruent with review objectives.
65	Nurse Migration in Australia, Germany, and the UK: A Rapid Evidence Assessment of Empirical Research Involving Migrant Nurses Smith J.B.; Herinek D.; Woodward-Kron R.; Ewers M. Policy, politics & nursing practice / 2022; DOI: 10.1177/15271544221102964 · Ref ID: 638317456	Not congruent with review objectives.
66	Nurses aged over 50 and their perceptions of flexible working. CLENDON, JILL; RN, PhD; WALKER, LEONIE / 2016;24(3):336-346	Not congruent with review

	DOI: 10.1111/jonm.12325 · Ref ID: 00019040-201604000-00009	objectives.

67	Nursing practice environment and employee silence about patient safety: The mediating role of professional discrimination experienced by nurses. Kritsotakis, George; Gkorezis, Panagiotis; Andreadaki, Eirini; Theodoropoulou, Maria; Grigoriou, Georgios; Alvizou, Anastasia; Kostagiolas, Petros; Ratsika, Nikoleta / 2022;78(2):434-445 DOI: 10.1111/jan.14994 · Ref ID: 00004471-202202000-00012	Not congruent with review objectives.
68	Out-of-pocket expenses related to aging in place for frail older people: a scoping review Moody, Elaine; Ganann, Rebecca; Martin-Misener, Ruth; Ploeg, Jenny; Macdonald, Marilyn; Weeks, Lori E.; Orr, Elizabeth; McKibbon, Shelley; Jefferies, Keisha / 2022;20(2):537-605 / DOI: 10.11124/JBIES-20-00413 · Ref ID: JBIES-20 00413	Not congruent with review objectives.
69	Participatory implementation research in the field of migrant health: Sustainable changes and ripple effects over time. van den Muijsenbergh, Maria; MD, PhD; LeMaster, Joseph; Shahiri, Parmida; Brouwer, Michelle; Hussain, Mohammed; Dowrick, Chris; BA, MSc; MD, FRCGP; Papadakaki, Maria; BSW, MPH; Lionis, Christos; MD, PhD; MacFarlane, Anne / 2020;23(2):306-317 DOI: 10.1111/hex.13034 · Ref ID: 00126350-202003000-00008	Not congruent with review objectives.
70	Predictors of nurses' turnover intention at one and five years' time. Labrague, L.J.; RN, MAN; DM, CHSE; De los Santos, J.A.A.; Falguera, C.C.; RN, RM; Nwafor, C.E.; Galabay, J.R.; Rosales, R.A.; Firmo, C.N.; RN, MHS; MAN, PhD / 2020;67(2):191-198 DOI: 10.1111/inr.12581 Ref ID: 00004396-202005000-00008	Not congruent with review objectives.

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72	Railways in world war one: Their place in the Australasian military railways journey - part 1 Hopkins-Weise, Jeff; Shiels, Rob Sabretache 2018;59(2):16-26 2018	Not congruent with review objectives.
73	Recruitment of nurses from India and their experiences of an Overseas Nurses Program. Stubbs, Fiona; BSc, RN / 2017;22(3):176-183 DOI: 10.1111/nicc.12181 · Ref ID: 00115812-201705000-00010	Not congruent with review objectives.
74	Regulation, migration and expectation: internationally qualified health practitioners in Australia-a qualitative study Cooper M.; Rasmussen P.; Magarey J. Human resources for health / 2020;18(1):74 DOI: 10.1186/s12960-020-00514-7 · Ref ID: 633138656	Not congruent with review objectives.
75	Response to: Roberts, D. 2016. Editorial: Should mental health nursing have a separate registration?. Cross, Wendy; RN, PhD / 2017;26(9-10):e1 DOI: 10.1111/jocn.13559 · Ref ID: 00019038-201705000-00027	Not congruent with review objectives.
76	Return to Nursing: A Meta-Synthesis of Academic Bridging Programs' Effects on Internationally Educated Nurses Cruz, EV; Felicilda-Reynaldo, RF; Mazzotta, CP Qualitative Report 2017;22(4):1092-1111 2017	Not congruent with review objectives.
77	Survivorship Care Practices and Confidence of Oncology Nurses in Singapore: A Cross-Sectional Study. Siew, An; Ling RN, BN; Tay, Li; Hui RN, BN; Ang, Wei; How Darryl RN, BN; Lopez, Violeta; RN, PhD / 2020;31(5):451-459 DOI: 10.1177/1043659619872792 · Ref ID: 00002045-202009000-00004	Not congruent with review objectives.
78	The experiences of foreign-educated nurses in Japan: a systematic review. Abuliezi, R.; Kondo, A.; RN, PhD; Qian, H.L.; RN, BSN / 2021;68(1):99-107 DOI: 10.1111/inr.12640 · Ref ID: 00004396-202102000-00014	Not congruent with review objectives.

79	The Experiences of Internationally Qualified Registered Nurses Working in the Australian Healthcare System: An Integrative Literature Review. Chun Tie, Ylona; RN, BNSc; MAdvNsgPrac, GCertHlthProfEd; MACCN, MACN; Birks, Melanie; RN, PhD; MEd, BN; Mills, Jane; MEd, MN / 2018;29(3):274-284 DOI: 10.1177/1043659617723075 · Ref ID: 00002045-201805000-00008	Not congruent with inclusion criteria.
80	The factors impacting personal and professional experiences of migrant nurses in Australia: An integrative review Chok, HN; Mannix, J; Dickson, C; Wilkes, L COLLEGIAN 2018;25(2):247-253 DOI: 10.1016/j.colegn.2017.06.004	Not congruent with inclusion criteria.
81	The impact of intersectionality on nursing leadership, empowerment and culture: A case study exploring nurses and managers' perceptions in an acute care hospital in Aotearoa, New Zealand. Aspinall, Cathleen; RN, MSc; Jacobs, Stephen; Frey, Rosemary Journal of Clinical Nursing/ 2021;30(13-14):1927-1941 DOI: 10.1111/jocn.15745 · Ref ID: 00019038-202107000-00013	Not congruent with review objectives.
82	The importance of cultural fit in the success of internationally qualified nurses: A comment on Brunton & Cook (2018). Hardcastle, Mary-Ann International Journal of Nursing Studies / 2018;87(Brunton, M., & Cook, C. (2018). Dis/integrating cultural difference in practice and communication: a qualitative study of host and migrant registered nurse perspectives from New Zealand. Int. J. Nurs. Stud., 83, 18-24. http://dx.doi.org/10.1016/j.ijnurstu):148 Netherlands Elsevier ScienceNetherlands 2018 / DOI: 10.1016/j.ijnurstu.2018.08.001https://dx.doi.org/10.1016/j.ijnurstu.2018.08.001 Ref ID: 2018-53968-017	Not congruent with review objectives.
83	The long history of Indigenous nursing The Lamp 2018;75(6):24-25 2018	Not congruent with review objectives.

84	The need to capture the unharnessed expertise of overseas educated nurses working as care support workers in their host country. Davis, Dilla; PhD, FHEA; Pradeep, Agimol / 2022;30(4):847-848 DOI: 10.1111/jonm.13410 Ref ID: 00019040-202205000-00002	Not congruent with review objectives.

85	The Role of Nurses in Advancing the Objectives of the Global Compacts for Migration and on Refugees. Shaffer, Franklin; EdD, RN; FAAN, FFNMRCSI; Bakhshi, Mukul; Farrell, Niamh; Alvarez, Thomas / 2019;43(1):10-18 DOI: 10.1097/NAQ.0000000000000328 Ref ID: 00006216 201901000- 00005	Not congruent with review objectives.
86	The Role of Schools of Nursing in Continuing Professional Education Provision. Haarsager, Jennie E. Australian Nursing & Midwifery Journal 10//Oct-Dec2018 2018;26(4):24- 25 Ref ID: 131964478	Not congruent with review objectives.
87	The transition of overseas qualified nurses and midwives into the Australian healthcare workforce. Se Ok Ohr Australian Journal of Advanced Nursing 12//Dec2016-Feb2017 2016;34(2):27-36 Ref ID: 120019922	Not congruent with review objectives.
88	The tyranny of size: Challenges of health administration in Pacific Island States Taylor, R Asia Pacific Journal of Health Management 2016;11(3):65-74 2016	Not congruent with review objectives.
89	Transition experiences of internationally qualified health care professionals: A narrative scoping review. Safari, Kolsoom; McKenna, Lisa; Davis, Jenny International Journal of Nursing Studies 05// 2022;129: DOI: 10.1016/j.ijnurstu.2022.104221 · Ref ID: 156377786	Not congruent with review objectives.

90	Transition experiences of internationally qualified midwives practising midwifery in Australia Javanmard, M; Steen, M; Vernon, R; Cooper, M Women And Birth 2020;33(3):E234- DOI: 10.1016/j.wombi.2019.05.002	Not congruent with review objectives.
91	Transition-to-U.S. Practice Experiences of Internationally Educated Nurses: An Integrative Review. Ghazal, Lauren; Ma, Chenjuan; Djukic, Maja; Squires, Allison / 2020;42(5):373-392	Not congruent with review objectives.

	DOI: 10.1177/0193945919860855 · Ref ID: 00008136-202005000-00008	
92	Transitional Experiences of Internationally Qualified Midwives Practicing in Australia: Protocol for a Mixed Methods Study Javanmard, M; Steen, M; Vernon, R; Cooper, M JMIR Research Protocols 2019;8(6): 2019 DOI: 10.2196/13406	Not congruent with inclusion criteria.
93	Transnational Motherhood: Health of Hispanic Mothers in the United States Who Are Separated From Children. Mccabe, Brian E.; Mitchell, Emma M.; Gonzalez-Guarda, Rosa Maria; Peragallo, Nilda; Mitrani, Victoria B. Journal of Transcultural Nursing 05// 2017;28(3):243-250 DOI: 10.1177/1043659616644960 · Ref ID: 122949489	Not congruent with review objectives.
94	Transnational parent-child separation and reunion during early childhood in Chinese migrant families: An Australian snapshot Hui, Yat Man Louise; Stevenson, Julie; Gallego, Gisselle Australian Journal of Child and Family Health Nursing 2019;16(1):16-23 Perth Cambridge Publishing 2019	Not congruent with review objectives.
95	Australian elections don't usually garner much attention abroad but New Zealand's opposition's party had weighed in on Labor's plan to rely on skilled migrants to boost the aged care workforce. Lette, Kathy; Baird, Julia; Yabsley, Michael; Lewis, Peter; Ryan, Christina; Reti, Shane; Wong, Penny; McLachlan, Gillon/ 12 Apr 202 2022;2022(412): ABC TV 2022	Not congruent with review objectives.

96	Use of iPhones by Nurses in an Acute Care Setting to Improve Communication and Decision-Making Processes: Qualitative Analysis of Nurses' Perspectives on iPhone Use Farrell, M JMIR Health And Uhealth 2016;4(2):147-154 2016 DOI: 10.2196/mhealth.5071	Not congruent with review objectives.
97	Useful tips for teaching international nursing students Henderson, Saras Australian Nursing and Midwifery Journal 2016;24(3):39 2016 PMID 29244469	Not congruent with review objectives.
98	Validity and reliability of the Perceived Perioperative Competence Scale- Revised. Sonmez, Betul; PhD, BSN; Ayoglu, Tuluha / 2019;21(4):428-435 DOI: 10.1111/nhs.12612· Ref ID: 00128699-201912000-00005	Not congruent with review objectives.
99	What are the support needs of nurses providing emergency care in rural settings as reported in the literature? A scoping review Burrows, Georgina L; Calleja, Pauline; Cooke, Marie Rural and Remote Health 2019;19(2):[147] [157] DOI: 10.22605/RRH4805	Not congruent with review objectives.
100	White dominance in nursing education: A target for anti-racist efforts. Bell, Blythe / 2021;28(1):e12379 DOI: 10.1111/nin.12379 · Ref ID: 00042640-202103000-00009	Not congruent with review objectives.
101	Why do China-educated nurses emigrate? A qualitative exploration Zhou, YX; Roscigno, C; Sun, QH International Journal of Nursing Studies 2016;53():163-172 2016 DOI: 10.1016/j.ijnurstu.2015.08.008	Not congruent with review objectives.

Appendix 5

JBI Critical appraisal checklist for qualitative research and JBI Critical Appraisal checklist for Analytical Cross-Sectional studies



JBI Critical Appraisal Checklist for Qualitative Research

Reviewer_____Date_____

Author _____Year_____Record Number_____

		Yes	No	Unclear	Not applicable
1.	Is there congruity between the stated philosophical perspective and the research methodology?	☐	☐	☐	☐
2.	Is there congruity between the research methodology and the research question or objectives?	☐	☐	☐	☐
3.	Is there congruity between the research methodology and the methods used to collect data?	☐	☐	☐	☐
4.	Is there congruity between the research methodology and the representation and analysis of data?	☐	☐	☐	☐
5.	Is there congruity between the research methodology and the interpretation of results?	☐	☐	☐	☐
6.	Is there a statement locating the researcher culturally or theoretically?	☐	☐	☐	☐
7.	Is the influence of the researcher on the research, and vice- versa, addressed?	☐	☐	☐	☐
8.	Are participants, and their voices, adequately represented?	☐	☐	☐	☐
9.	Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	☐	☐	☐	☐
10.	Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

_____

_____

Appendix 6



JBI Critical Appraisal Checklist for Analytical Cross Sectional Studies

Reviewer_____Date_____

Author _____Year_____Record Number_____

	Yes	No	Unclear	Not applicable
1. Were the criteria for inclusion in the sample clearly defined?	☐	☐	☐	☐
2. Were the study subjects and the setting described in detail?	☐	☐	☐	☐
3. Was the exposure measured in a valid and reliable way?	☐	☐	☐	☐
4. Were objective, standard criteria used for measurement of the condition?	☐	☐	☐	☐
5. Were confounding factors identified?	☐	☐	☐	☐
6. Were strategies to deal with confounding factors stated?	☐	☐	☐	☐
7. Were the outcomes measured in a valid and reliable way?	☐	☐	☐	☐
8. Was appropriate statistical analysis used?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

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JBI Data Extraction Tool for Research

First author and year	
Methodology	
Method	
Phenomenon of Interest	
Setting	
Geographical	
Cultural	
Participants	
Data analysis	
Author conclusion	
Comments	

Chapter Four

Study Two: What are the cultural and linguistic characteristics of the nursing workforce in Australia?

4.1 Introduction

Chapter Four attempts to answer the second research question: What are the cultural and linguistic characteristics of the nursing workforce in Australia? This chapter presents a publication addressing this question, and a discussion of the article's relevance to this body of research.

4.2 Relevance of the article to this body of research

The results of the systematic review (Chapter Three) raised several questions about the professional integration of internationally qualified nurses (IQNs) in Australia. For example, why have most of the barriers to professional integration remained unchanged over the past 24 years? And why do these barriers persist, despite being well understood? Another avenue of inquiry was to understand the evolution of IQN data over the last eight years, assessing whether the proportion of IQNs in the Australian workforce has increased and identifying the predominant nationalities among IQNs.

This led to the central question for Study Two: What are the cultural and linguistic characteristics of the nursing workforce in Australia? A quantitative approach, based on a positivist paradigm, was used to conduct a secondary analysis of existing databases, drawing on descriptive statistics. An analysis was conducted using data from the Australian Government Department of Health and Aged Care Nurses and Midwives Dashboard (Australian Government Department of Health and Aged Care, 2023) and the Organisation for Economic Co-operation and Development (OECD) Health Workforce Migration Dashboard

(OECD, 2023). A closer examination of the Nurses and Midwives Dashboard, covering the period from 2016 to 2022, revealed that 43% of the Australian nursing workforce comes from a culturally and linguistically diverse (CALD) background. However, this number includes both IQNs and locally qualified nurses (LQNs) who were born overseas.

Given this significant multicultural mix of the nursing workforce, it seems possible that it is not only IQNs and international students who might face some of the difficulties identified in the systematic review: overseas-born LQNs may experience similar difficulties. With this in mind, the literature was further examined to explore strategies used to address cultural competence in the context of healthcare delivery and to consider their relevance to relationships among nurses. This included concepts such as cultural safety and cultural humility, as well as various theoretical approaches used by different authors to define and explain cultural competence. While these concepts were originally developed to enhance the quality of care provided to patients, they were not specifically intended to address interactions and relationships among nurses themselves. This led to the proposition of intra-professional cultural competence (IPCC), derived from the concept of cultural competence described by Cross et al. (1989), as a potential strategy to support LQNs from CALD backgrounds who were born or educated in Australia, as well as IQNs. The article in this chapter explains the rationale for using the term "cultural competence" over other more current terminology, such as cultural humility or cultural safety.

Cultural safety was originally developed in New Zealand to help healthcare professionals meet the health needs of the indigenous population (Papps & Ramsden, 1996). Similarly, cultural humility, first introduced for use in medical education (Tervalon & Murray-García, 1998), also aims to address power imbalances in physician–patient interactions. Both concepts are based on the idea that power imbalances may occur during clinical encounters involving healthcare professionals and students, patients or service users. Additionally, cultural humility emphasises a lifelong commitment to self-evaluation and reflection, necessitating personal transformation and dedication (Chávez, 2018; Foronda, 2020; Foronda et al., 2016).

The concept of cultural competence (Cross et al., 1989) was chosen for use in this research because IPCC focuses on interactions between nurses who, in theory at least, hold similar levels of power. Additionally, these interactions occur within a professional setting rather

than as part of a clinical encounter. The term *competence* refers to the possession of the knowledge, skills and attitudes required to perform a task or fulfil a role effectively (Mrayyan et al., 2023; Nabizadeh-Gharghozar et al., 2021). It is a broader concept that encompasses overall capability or suitability for a specific role, rather than a specific outcome, experience or occurrence. Arguably, it is possible for individuals to be trained to acquire this competence. This approach provides an alternative for professionals who may be unwilling to engage in lifelong self-reflection, but still need to work in multicultural teams.

Research indicates that intra-professional collaboration enhances care delivery (Schön Persson et al., 2018; Ylitörmänen et al., 2023) and fosters team cohesion, a positive work environment and overall wellbeing (Ylitörmänen et al., 2023). A supportive work environment is known to influence job satisfaction and staff retention (Ulrich et al., 2019), while the harmful physical and psychological effects of racism, discrimination, bullying and harassment impact both those directly affected and those with vicarious experiences (Báez-León et al., 2016; Cardoso et al., 2016; Hong et al., 2022). IPCC aims to promote mutual collaboration and professional relationships, prevent racism and discrimination among nurses, and encourage respect for the diverse values, attitudes and beliefs of colleagues, thereby enhancing responses to cross-cultural interactions (Correa-Betancour et al., 2024). Integrating IPCC as a strategy to support all nurses, but especially those from CALD backgrounds, could therefore have a positive impact.

The article contained within this chapter concludes by identifying the potential benefits of implementing IPCC as a strategy to enhance the professional integration and interactions of nurses within the Australian healthcare context. It was submitted to a high impact journal (impact factor 1.4) in September 2024, and accepted for peer review on 3 October 2024.

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4.3 Submitted paper: Intra-professional cultural competence: exploring a strategy to support Australia's culturally and linguistically diverse nursing workforce

4.3.1 Abstract

The objective of this study is to provide a possible strategy to enhance professional integration through education relating to a new concept – intra-professional cultural competence (IPCC). This concept primarily focuses on the interactions between nurses within the workplace.

Background: Australia's nursing workforce is starting to reflect the nation's diverse population. In 2022, 43% of the nursing workforce was born overseas, with 22% being internationally qualified nurses and 21% locally qualified but overseas-born nurses. As a result, up to 43% of the workforce may potentially be culturally and linguistically diverse. The source for locally qualified, overseas-born nurses are first generations of migrants and international students who remain working in Australia after graduation. This latter group has been steadily rising. These three groups of nurses – overseas-born first-generation immigrants, international nursing graduates and internationally qualified nurses – may face similar challenges to integrate into the workforce. Among the most frequently mentioned challenges for international students and internationally qualified nurses are language barriers, differences in communication patterns, and situations related to racism, discrimination, bullying and harassment.

Study design and methods: This article is structured as a discussion paper, grounded in research and backed by relevant literature.

Findings: This paper defines IPCC as: "A set of congruent behaviours and attitudes that enable professionals to work respectfully and effectively in cross-cultural situations". IPCC involves four main domains: mutual collaboration; the prevention of racism, discrimination, bullying and harassment among nurses; respect of values, attitudes and beliefs of colleagues that may differ across cultures; and appropriate responses to cross-cultural interactions with colleagues.

The descriptor “cultural competence” was deliberately chosen over alternatives like cultural safety or cultural humility, recognising that these concepts mainly focus on the power dynamics between healthcare providers and patients, which may not always apply to interactions between healthcare professionals. “Competence” suggests having the skills, knowledge and abilities necessary for effective role fulfilment that could be developed through training and skill acquisition. Consequently, IPCC refers to the essential skills, knowledge and abilities required to engage respectfully and effectively in cross-cultural interactions with other nurses.

The relevance of this paper lies in identifying the growing proportions of both overseas-born, locally qualified nurses and internationally qualified nurses. Mutual collaboration and communication are essential in preventing incidents related to racism, discrimination, bullying and harassment, while also fostering team cohesion, wellbeing, job satisfaction and retention. Clear communication is crucial for maintaining quality care, ensuring patient safety and preventing fatalities. This is particularly important in multicultural teams, such as those commonly found in Australia, where a growing number of nurses may not speak English as their first language.

Keywords: Culturally and linguistically diverse nursing workforce, intra-professional cultural competence, cultural competence, internationally qualified nurses, healthcare workforce.

4.3.2 Implications for research, policy and practice

- With 43% of nurses being born overseas, the persistence of racism, discrimination, bullying and harassment within clinical settings highlights the gap between existing regulatory documents and their enforcement.
- Intra-professional cultural competence could positively influence communication, teamwork and mutual respect within nursing, leading to a potential reduction in racism, discrimination, bullying and harassment, improved nurse retention, and better overall quality of care.
- Strengthening intra-professional cultural competence frameworks at institutional, national and clinical levels, and incorporating them into orientation programs and continuous professional education, could serve as an effective strategy to address these issues.

4.3.3 What is already known about the topic?

- Overseas-born first-generation immigrants, international nursing students and internationally qualified nurses often encounter similar challenges when integrating into the workforce.
- Common issues for international students and internationally qualified nurses include language barriers, differences in communication styles, and experiences of racism, discrimination, bullying and harassment.

4.3.4 What this paper adds

- In 2022, about 43% of the Australian nursing workforce was born overseas, underlining the cultural diversity and significant need to address racism and discrimination in the sector.
- The concept of intra-professional cultural competence is presented as one strategy to address conduct and behaviour related to racism, discrimination, bullying and harassment in nursing practice.
- A means of aiding retention of internationally qualified nurses and locally qualified overseas-born nurses may be by increasing intra-professional cultural competence in the practice environment.

4.3.5 Background

Australia has a significant culturally diverse population. For example, nearly half (48%) of the Australian population has at least one parent born overseas and a substantial 28% of the population are first-generation immigrants (Australian Bureau of Statistics, 2022). This diverse demographic landscape is starting to be mirrored in the composition of the nursing workforce.

The surge in diversity within the nursing workforce can be attributed to various factors. Firstly, the diversity in Australian society has been a primary driver; secondly, the active recruitment of internationally qualified nurses; and thirdly the influx of international students into undergraduate nursing programs. An analysis of the Australian Government Department of Health and Aged Care (DOHA) Nurses and Midwives Dashboard between the period 2016–2022 (Australian Government Department of Health and Aged Care, 2023) shows that there

has been a steady increase in the number of nurses who obtained their initial qualification (Bachelor of Nursing to become a registered nurse [RN]) in Australia but were born overseas. This group of nurses consists of first-generation migrants who were born overseas but became permanent residents or citizens by the time they pursued their nursing studies, as well as international students who may hold various visa statuses that allow them to work in Australia. The percentage of overseas-born, locally qualified nurses increased from 16% in 2016 to 21% of the total workforce in 2022. The Nurses and Midwives Dashboard also shows that 22% of the RNs in the total Australian nursing workforce are internationally qualified nurses (Australian Government Department of Health and Aged Care, 2023). Standard measures for calculating the culturally and linguistically diverse (CALD) population utilised country of birth as a proxy measure (Australian Government Department of Health and Aged Care, 2023). For the purposes of this study, we have added the number of internationally qualified nurses and overseas-born locally qualified nurses to conclude that 43% of the Australian nursing workforce in 2022 was born overseas. In 2016, this percentage was only 38%, indicating a steady growth trend from 2016 to 2022. This trend has significant implications for the continued diversification of the nursing workforce.

To further understand the CALD nursing workforce in Australia, an analysis of the Organisation for Economic Co-operation and Development (OECD) Health Workforce Dashboard (OECD, 2023) provides interesting insights. The data establish that in 2021 the main countries of origin of nurses in Australia were India (23.5%), the UK (22.8%), the Philippines (18.9%) and New Zealand (10.6%), altogether comprising a substantial proportion of the internationally qualified nurses workforce (65%). Significantly, these four countries all have English as one of their official languages. Thus, for these nurses the language barrier may not be an issue, although there may still be cultural issues. Other countries of initial qualification of internationally qualified nurses in 2021 also include Ireland (2.8%), China (2.4%), Zimbabwe (2.1%) and the USA (1%), highlighting the diversity of nationalities within the nursing workforce.

For overseas-born, locally qualified nurses, information about their visa type or residency status is not available, making it impossible to disaggregate this data. Regarding international students, there has been a substantial rise in their enrolment across all sectors in Australia. There has been a 34% increase between the periods comprising January–July 2022 and

January–July 2023 (Department of Education, 2023b). The primary source countries for these students include China (21%), India (17%), Nepal (8%) and Colombia (5%), encompassing various educational levels such as English courses, vocational education and training, and all university levels. There has also been an increase in the enrolment of international nursing students. In 2021, 17,112 students graduated with a Bachelor of Nursing (BN), and 22% of these graduates were international students (Department of Education, 2023a).

It is possible to identify many factors that may contribute to the continuous rise in the number of both international nursing students and internationally qualified nurses. These include Australia's migration history, the Skills Migration Program policy (Villamin et al., 2023), and the availability of clear information for nursing registration (Nursing and Midwifery Board of Australia, 2022b). Additionally, research has identified pull factors frequently cited by internationally qualified nurses in Australia, such as improved working conditions (Zhou et al., 2016), higher income, and a sense of workplace and societal safety (Dywili et al., 2013; Garner et al., 2015; Pressley et al., 2022; Roth et al., 2021; Zhou et al., 2016). Consequently, it can be inferred that the immigration of international nursing students and internationally qualified nurses will continue to increase in the coming decades. Therefore, Australian nursing educational programs and workplaces need to develop a range of strategies to ensure the successful professional integration of these nurses.

4.3.6 Objective

The aim of this study is to quantitatively investigate the cultural and linguistic characteristics of the nursing workforce in Australia and to propose a potential strategy for improving their professional integration through education focused on a new concept– 'intra-professional cultural competence'.

4.3.7 Study design and methods

This discussion paper is grounded in research and backed by relevant literature.

Implications for professional integration

The presence of overseas born locally qualified nurses (first generation immigrants) and international nursing students who may work in the Australian setting on graduation (locally qualified nurses), plus the inclusion of internationally qualified nurses**,** significantly

contributes to the overall diversity within the nursing workforce. These groups of nurses represented 43% of the Australian nursing workforce in 2022, providing an insight into the diversity of cultures and languages that currently co-exist in the nursing workforce.

Given the potential cultural diversity of almost half the nursing workforce, there is the need for cultural integration within the profession. The literature reveals that both international nursing students and internationally qualified nurses have reported facing numerous cultural and linguistic challenges, as they navigate their professional integration into the Australian workforce. It is likely that locally trained nursing students who are first-generation immigrants and were born overseas experience similar challenges.

Research focusing on international nursing students in Australia has identified key hurdles faced in clinical settings that prevent them to fully participating in clinical placements. For instance, some international nursing students report that they experience communication barriers, including speaking and understanding English (rather than writing or reading) (Graham et al., 2024), mastering colloquialisms, clinical jargon, and softening their accent while communicating in English (Abu-Arab & Parry, 2015; Graham et al., 2024; Lim et al., 2023; Lin et al., 2021). Other challenges identified by educators are differences in communication styles and experiencing difficulties in being assertive (Abu-Arab & Parry, 2015). Additionally, a need to address differences in cultural norms and body language (Abu-Arab & Parry, 2015; Lin et al., 2021; Newton et al., 2018), difficulties in developing interpersonal interactions with patients and peers (Abu-Arab & Parry, 2015), and problems in developing a sense of belonging (Lim et al., 2023) have also been identified.

International nursing students also face challenges in clinical settings related to bullying, racism and discrimination. Some of these instances involve direct confrontation, such as public humiliation or verbal abuse (Birks et al., 2017; Budden et al., 2017; Graham et al., 2024). In other cases, students are prevented from providing full patient care or denied valuable learning opportunities preventing them growing into their professional role (Birks et al., 2017; Budden et al., 2017; Graham et al., 2024). Reports of physical aggression have also been noted (Birks et al., 2017; Hopkins et al., 2014). Others described instances of racism and discrimination as being indirect and subtle (Birks et al., 2017; Budden et al., 2017; Graham et al., 2024). The sources of these practices can vary, coming from clinical educators, clinical

placement staff (RNs, enrolled nurses, Assistant in Nursing), patients or visitors, or other nursing students (Birks et al., 2017; Budden et al., 2017; Graham et al., 2024; Hopkins et al., 2014). Discrimination can also originate from staff of different racial backgrounds, often based on perceived conflicts with their home countries (Graham et al., 2024).

It is also known that internationally qualified nurses encounter individual and social obstacles as they integrate professionally into the Australian workforce (Correa-Betancour, Marcus, et al., 2024). Obstacles include psychological adjustment to acculturation (Chun Tie et al., 2018; Crawford et al., 2016; Dywili et al., 2021; Joseph et al., 2022; Ng Chok et al., 2018; Philip, Woodward-Kron, & Manias, 2019; Vafeas & Hendricks, 2018) and communication barriers, including language proficiency (Chun Tie et al., 2018; Crawford et al., 2016; Ng Chok et al., 2018; Philip, Woodward-Kron, & Manias, 2019; Vafeas & Hendricks, 2018).

At the social level, internationally qualified nurses also deal with a wide range of issues. These can be related to the scope of practice and differences in their roles as nurses (Chun Tie et al., 2018; Ng Chok et al., 2018; Philip, Woodward-Kron, & Manias, 2019); inadequate support and incomplete induction programs (Chun Tie et al., 2018; Dywili et al., 2021; Mapedzahama et al., 2018; Ng Chok et al., 2018; Philip, Woodward-Kron, & Manias, 2019; Philip, Woodward-Kron, Manias, & Noronha, 2019; Zanjani et al., 2021); failure to acknowledge their previous qualifications and experiences (Chun Tie et al., 2018; Crawford et al., 2016; Dywili et al., 2021; Mapedzahama et al., 2018; Philip, Woodward-Kron, Manias, & Noronha, 2019; Vafeas & Hendricks, 2018); and instances of racism, discrimination, bullying and harassment (Chun Tie et al., 2018; Dywili et al., 2021; Joseph et al., 2022; Mapedzahama et al., 2018; Philip, Woodward-Kron, & Manias, 2019; Philip, Woodward-Kron, Manias, & Noronha, 2019; Zanjani et al., 2021). The sources of racism, discrimination, bullying and harassment may come from other colleagues, clinical team members, patients or visitors (Dywili et al., 2021; Joseph et al., 2022; Mapedzahama et al., 2018; Philip, Woodward-Kron, & Manias, 2019; Philip, Woodward-Kron, Manias, & Noronha, 2019). These behaviours can manifest in the form of limited opportunities for professional development, insubordination or open confrontation (Dywili et al., 2021); and oppositional interactions with colleagues, or marginalisation from non-professional activities or conversations (Parke et al., 2023).

The challenges faced by both these groups, international nursing students and internationally qualified nurses, have the potential to hinder their integration into the Australian nursing workforce, by affecting nursing relationships, communication, work satisfaction and retention, consequently impacting the overall quality of care. These challenges may be similar to those faced by overseas-born, locally qualified nurses who are first-generation immigrants. Taking into account the range of backgrounds represented in the Australian workforce previously shown, it is imperative to implement actions that enhance the retention and support of this heterogeneous workforce.

Situations linked to racism, discrimination, bullying and harassment can have devastating effects on the mental and physical health of nurses, as well as on organisational effectiveness. Psychological effects include depression (Yildirim, 2009), emotional stress, vulnerability, frustration and burnout (Karatuna et al., 2020; Shorey & Wong, 2021), all of which can impair job performance and the ability to provide high quality nursing care (Karatuna et al., 2020; Shorey & Wong, 2021; Yildirim, 2009). Physical effects may manifest as headaches, tachycardia, fatigue, sleep disorders, pseudo-neurological symptoms and gastrointestinal issues (Karatuna et al., 2020). Regarding the organisation, behaviours related to racism, discrimination, bullying and harassment exacerbate intentions to leave, leading to decreased retention rates, and lower job satisfaction, productivity and commitment, as well as increased errors that impact quality of care and patient safety (Karatuna et al., 2020). A national consultation in Australia revealed that 28% of CALD nurses reported experiencing racism (Department of Health and Age Care, 2024).

The global shortage of RNs has intensified, particularly in high-income countries like Australia, prompting a reliance on the recruitment and retention of internationally qualified nurses to address workforce gaps (Organisation for Economic Co-operation and Development, 2016; World Health Organisation, 2020). Several factors contribute to the escalating demand for nurses, including demographic shifts and increasing healthcare quality standards. High-income countries are witnessing changes in their demographic profiles, marked by declining birth rates, increased life expectancy and an overall ageing population, including within the nursing profession (Marc et al., 2019). The elevation of quality standards has concurrently generated an escalating demand for additional nursing professionals. This demand is driven, in part, by the imperative to enhance score-per-patient ratios (Margadant et al., 2020), nurse-

to-patient ratios (Driscoll et al., 2018; McHugh et al., 2021), and the evolving landscape of specialised nursing care (Marc et al., 2019). Even though Australia has a high proportion of nurses per 1000 inhabitants (12.8 in 2021), there is still a gap of 128,499 nurses projected by 2030 (Scheffler & Arnold, 2019). Given the current nursing shortfall, increasing the number of international nursing students and attracting internationally qualified nurses to the Australian workforce has become an imperative (Villamin et al., 2023). We turn now to consider whether implementing intra-professional cultural competence may be instrumental in addressing the problems of racism, discrimination, bullying and harassment, and address and improve the issues of recruitment and retention.

From cultural competence to intra-professional cultural competence

Cultural competence in nursing is a well understood and much documented requirement (Cassidy, 2024; Qin, 2021; Sharifi et al., 2019; Shen, 2015; Young & Guo, 2016). Since it was first mentioned, by Madeleine Leininger in the 1970s, the nursing profession has included the concept of cultural competence in their curriculum (Leininger, 1966, 1978). The focus has been to improve the possession of suitable skills, knowledge or abilities needed to perform a task or fulfil a role effectively. Research has shown that training in cultural competence impacts positively on increasing the knowledge, awareness and sensitivity of practitioners (Chae et al., 2020; Renzaho et al., 2013; Vella et al., 2022), and has positive effects on patients' satisfaction and trust (Govere & Govere, 2016; Tang et al., 2019; Vella et al., 2022). However, the literature and regulatory documents usually (although not always) refer to the relationships between nurses and their patients and families, rather than peer-to-peer relationships (Correa-Betancour, Chiarella, & Short, 2024). It is for this reason the authors have modified the definition of cultural competence outlined by Cross et al. (1989) and developed the concept of intra-professional cultural competence as a tool that might positively influence relationships between professional colleagues (Correa-Betancour, Chiarella, & Short, 2024).

This definition of intra-professional cultural competence predominantly addresses the interactions among nurses within the workplace, and it could be similarly applicable to other professionals occupying comparable positions of relatively equal authority. The concept of "cultural competence" was intentionally chosen over other alternatives like cultural safety or

cultural humility. This decision was based on the acknowledgement that concepts like cultural safety or cultural humility primarily address power dynamics between healthcare providers and patients, dynamics that do not always apply to interactions amongst healthcare professionals themselves. These interactions typically occur within clinical or professional settings and are different from those occurring in clinical encounters.

For instance, the concept of cultural humility was introduced by Tervalon and Murray-García (1998) to be used in medical education to address the possible power imbalance between healthcare professionals and patients or students during clinical encounters. Cultural humility is defined as "a lifelong commitment to self-evaluation and critique, to redressing power imbalances . . . and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-García, 1998, p. 123). Openness, self-awareness, egoless, supportive interactions, and self-reflection and critique were defined as the attributes of cultural humility (Foronda et al., 2016). It is also acknowledged as a lifelong learning process that demands personal transformation and a dedication to continuous reflection and self-assessment of personal actions (Chávez, 2018). The concept of cultural humility was later clarified, defining it as a "process of self-reflection to understand personal and systemic biases and privilege" (Foronda et al., 2022). The framework aimed to aid healthcare professionals in recognising situations where they exert authority over their patients or students and to promote the adoption of traits such as openness, self-awareness, humility and adaptability.

There is no agreement about the use of the concepts of cultural humility and cultural competence. While some authors consider cultural humility a more comprehensive and superior approach (Jang, 2023; Lekas et al., 2020), there are other views where cultural humility is seen as a component of cultural competence (Danso, 2018; Ross, 2010) or a complement of it ("*competemility*") (Campinha-Bacote, 2018; Nguyen et al., 2021; Stubbe, 2020). Although the cultural competence framework has faced some criticism, most of the concerns are centred around its application in the delivery of care (Kumagai & Lypson, 2009; Lekas et al., 2020; Stubbe, 2020). One criticism is based on the idea that cultural competence is a static concept (Furlong & Wight, 2011; Herring et al., 2013). Another critique is related to the possible risk of stereotyping or stigmatising patients by healthcare professionals (Isaacson, 2014; Kumagai & Lypson, 2009; Lekas et al., 2020). However, numerous authors

have contributed to the definition and evolution of the concept of cultural competence. Some scholars argue that cultural competence is a continuous, ever-evolving process, rather than a fixed achievement (Crigger et al., 2006; Greene-Moton & Minkler, 2020; Isaacson, 2014). Cultural competence has been also described as a complex educational process involving cognitive, practical and emotional aspects, where confidence and transcultural skills are vital (Jeffreys & Dogan, 2012).

For the purposes of this and previous papers, intra-professional cultural competence is defined as: "A set of congruent behaviours and attitudes that enable professionals to work respectfully and effectively in cross-cultural situations" (Correa-Betancour, Chiarella, & Short, 2024). Arising from the literature surrounding definitions of cultural competence and applying these to intra-professional cultural competence, the concept of intra-professional cultural competence involves four main domains: a) mutual collaboration and professional relationships; b) the prevention of racism and discrimination among nurses; c) respect for values, attitudes and beliefs of colleagues that may differ across cultures; and d) an appropriate response to cross-cultural interactions with colleagues.

Mutual collaboration and professional relationships in nursing are associated with elements such as job satisfaction and staff retention (Ulrich et al., 2019), delivering high-quality care (Schön Persson et al., 2018; Ylitörmänen et al., 2023), and enhancing team cohesion, a positive work environment and wellbeing (Ylitörmänen et al., 2023). Maintaining clear communication is significantly important in the nursing role for preserving quality care, ensuring patient safety and preventing patient fatalities (Raeisi et al., 2019). But it is specifically important in multicultural teams, such as those commonly found in the Australian nursing workforce. The literature in the Australian clinical setting indicates that interactions between locally qualified nurses and internationally qualified nurses are typically short, focused on tasks, and often lacking in casual or interpersonal aspects, regardless of their English proficiency (Brunton & Cook, 2018; Dywili et al., 2021; Mapedzahama et al., 2018; Philip, Woodward-Kron, & Manias, 2019; Philip, Woodward-Kron, Manias, & Noronha, 2019).

The prevention of situations linked to racism, discrimination, bullying and harassment could be linked to strengthening the respect for values, attitudes and beliefs of colleagues that may differ across cultures and also to managing appropriate responses to cross-cultural

interactions with colleagues. Boosting intra-professional cultural competence could foster greater mutual collaboration, through sharing of knowledge and skills and improving communication, especially among nurses whose first language is not English.

The concept of "competence" implies having the necessary skills, knowledge or abilities required for effective task performance or role fulfilment. Being "competent" encompasses a broader spectrum of overall capability and suitability for a specific purpose or role. Competence can be developed through training and the acquisition of skills. Intra-professional cultural competence would provide the basic skills, knowledge and abilities to perform respectfully and effectively in cross-cultural situations with other nurses. The emphasis on the concept of "basic" underscores its significance as a starting point or minimum requirement for professionals who may not engage in lifelong self-reflection processes but are nonetheless required to work in multicultural teams. In nursing, neglecting intra-professional cultural competence in relationships with colleagues can lead to adverse consequences for patients and missed nursing care (He et al., 2022; Hogh et al., 2018). Therefore, intra-professional cultural competence should be regarded as a foundational standard, rather than solely relying on individual qualities.

Improving the inclusivity of the work environment for nurses is an ethical obligation that demands an individual, organisational and collective effort, with everyone committed and trained to achieve it. Recognising the significance of intra-professional cultural competence in nursing practice could be instrumental in this regard. This inclusive approach is already articulated in some Australian nursing regulatory documents, particularly in the Nursing and Midwifery Board of Australia (NMBA) Code of Conduct (Nursing and Midwifery Board of Australia, 2022a). It will be important to reinforce these principles at every level, from early university education to clinical placements, as well as in workplace orientation and induction programs. Further research would be beneficial in uncovering the preparedness levels of universities, nurses and managers regarding intra-professional cultural competence. Additionally, exploring the influence of policies and regulatory documents on organisational culture, leadership and the relationships among nurses will be important to explore how effective these documents are in behaviour change. Specific training on intra-professional cultural competence could also potentially mitigate practices associated with racism, discrimination, bullying and harassment in the workplace. Although the effectiveness of intra-

professional cultural competence has not yet been proven empirically, there is a need for future research to determine its effectiveness.

4.3.8 Conclusion

The growing diversity of cultures and languages within the Australian nursing workforce poses challenges across various levels. Enhancing understanding and training in intra-professional cultural competence could serve as a valuable strategy for mitigating issues arising from interactions among nurses from diverse cultural and linguistic backgrounds. Understanding the CALD nursing workforce can provide valuable insights into the challenges encountered by both internationally qualified nurses and overseas-born, locally qualified nurses in Australia. The analysis of the workforce data undertaken for this paper points to the added relevance of the need to develop targeted approaches to address these challenges in nursing, thereby enhancing attraction and retention within the Australian workforce. Implementing strategies such as intra-professional cultural competence is suggested, as it may promote attitudes, skills and behaviours in the workplace that could contribute to recruitment and retention efforts, especially given the current global nursing shortage, with the aim of enhancing the wellbeing of our nurses and the quality of nursing care in Australia.

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Chapter Five

Study Three: What steps have been taken by regulators to address the barriers and facilitators to the professional integration of internationally qualified nurses in Australia? How effective has this approach been?

5.1 Introduction

Chapter Five addresses the third and fourth research questions: What steps have been taken by regulators to address the barriers and facilitators to the professional integration of internationally qualified nurses (IQNs) in Australia? How effective has this approach been?

This chapter includes a peer-reviewed published manuscript, with a preceding discussion of the relevance of the article to the broader body of research and a publication statement. The chapter concludes by exploring whether there have been any changes to nurse regulatory documents analysed in the UK, New Zealand or Australia in relation to IPCC.

5.2 Relevance of the article to this body of research

This article was published in 2024 in the journal *Nursing Inquiry* (impact factor 2.3 in 2023). In this publication, the concept of intra-professional cultural competence (IPCC) was coined. As explained in Chapter Three, an adapted definition of cultural competence, as proposed by Cross et al. (1989), was used to define IPCC as: "A set of congruent behaviours and attitudes that enable professionals to work respectfully and effectively in cross-cultural situations".

Three sets of regulatory documents from three countries were then analysed, using the IPCC framework. The source documents used in this publication were:

- Standards for practice
  - *Future nurse: Standards of proficiency for registered nurses* (2018), published by the Nursing and Midwifery Council of the UK (NMC)
  - *Competencies for registered nurses* (2022), published by the Nursing Council of New Zealand (NCNZ)
  - *Registered nurse standards for practice* (2016), published by the Nursing and Midwifery Board of Australia (NMBA).
- Codes of professional conduct
  - *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates* (2018), published by the UK NMC
  - *Code of Conduct for nurses* (2012), published by the NCNZ
  - *Code of Conduct for nurses* (2018), published by the NMBA.

A content analysis methodology was employed, specifically using semantic analysis and latent coding to uncover implicit meanings within the texts (Neuman, 2021). All the documents analysed were publicly accessible on the respective organisations' websites. After a thorough reading, each document was examined through the content review process, aimed at identifying elements of IPCC. A coding system comprising four themes was established for the analysis, in accordance with the definition of IPCC provided.

It is hoped that the results might benefit nursing education, practice and research, and be valuable for other countries and settings considering enhancing intra-professional cultural competence. This article was accepted for publication on 17 June 2024.

5.3 Publication Statement

Statement from co-authors confirming the authorship contribution of the PhD candidate:

As co-authors of the manuscript

> **Correa-Betancour, M**., Chiarella, M., & Short, S. D. (2024). Intraprofessional cultural competence in nursing regulation: A critical content analysis of standards and codes

in the United Kingdom, New Zealand and Australia. *Nursing Inquiry*, *31*(4), Article e12652. https://doi.org/10.1111/nin.12652

we confirm that **Marcela Correa-Betancour** has made the following contributions:

- Conception and design of the research
- Literature search
- Data collection
- Analysis, and interpretation of data
- Writing and revising the manuscript
- Critical appraisals of content
- Response to peer reviewers
- Final approval of the version to be published.

5.4 Published paper

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ORIGINAL ARTICLE

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Intraprofessional cultural competence in nursing regulation: A critical content analysis of standards and codes in the United Kingdom, New Zealand and Australia

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Abstract

There is a global shortage of nurses, leading many countries to recruit internationally qualified nurses (IQNs) to fill the gap. However, IQNs encounter challenges in integrating into their new professional environment, particularly in their interactions with locally qualified nurses (LQNs). Intraprofessional cultural competence (IPCC), defined as 'a set of congruent behaviours and attitudes that enable professionals to work respectfully and effectively in cross-cultural situations', may be a strategy to address these challenges. Content analysis was used to examine nursing regulatory documents (Standards for Practice [Standards] and Codes of Conduct [Codes]) from the United Kingdom, New Zealand and Australia. Data were extracted and organised based on four key themes relevant to IPCC. The analysis revealed a focus on 'Mutual collaboration and professional relationships' in six regulatory documents, with explicit commitments to preventing racism and discrimination in the Australian and NZ Codes. However, issues such as racism, discrimination, bullying and harassment faced by IQNs are not comprehensively addressed, as the documents mainly prioritize culturally appropriate patient interactions over relationships between colleagues. Using regulatory documents to address IPCC may influence positive change such as improving communication, and preventing racism, bullying, discrimination and harassment within nursing.

KEYWORDS

code of conduct, cultural competence, global nursing workforce, internationally qualified nurses, intraprofessional cultural competence, nursing practice, nursing regulation, standards for practice

This research was conducted during online meetings and at the Susan Wakil Health Building, Faculty of Medicine and Health, The University of Sydney, Western Ave, Camperdown New South Wales 2050, Sydney, Australia.

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1 | INTRODUCTION

In recent years, there has been an increasing gap between the supply and demand of nurses worldwide (Negin et al., 2016; Shaffer et al., 2022). Many factors have intensified the gap post COVID-19 pandemic, with stress and burnout, prolonged absences, turnover and early retirement (Shaffer et al., 2022) frequently mentioned. Pre pandemic, the global nursing shortage was estimated at 5.9 million (Shaffer et al., 2022) and these projections have increased. For instance, in the United Kingdom a shortage of 96,872 nurses is projected by 2030. In New Zealand the shortage is estimated at 4800 nurses to date (Te Whatu Ora—Health New Zealand, 2023). In Australia, a shortage of 128,499 nurses is expected by 2030 (Scheffler & Arnold, 2019).

Many high-income countries have used the recruitment of internationally qualified nurses (IQNs) as a strategy to address their nursing workforce requirements (Marcus & Short, 2014; Organization for Economic Cooperation and Development, 2016; Short et al., 2012; World Health Organization, 2020). As a result, in the United Kingdom, New Zealand and Australia, the percentages of IQNs are increasing. For instance, in New Zealand IQNs provide 26% of the nursing workforce, in the United Kingdom 15% and in Australia 18% (Organization of Economic Cooperation and Development, 2020)., In areas such as aged care, the concentration is about 40% (Australian Bureau of Statistics, 2022).

Despite this growing need for IQNs, there are barriers to their professional integration, and subsequently their retention. Some frequently identified barriers are the need for psychological adaptation (Chun Tie et al., 2018; Marcus et al., 2014; Ng Chok et al., 2018; Pung & Goh, 2017; Safari et al., 2022) issues in language skills and communication (Brunton & Cook, 2018; Brunton et al., 2019, 2020; Chun Tie et al., 2018; Kim & Guo, 2021; Kuzemski et al., 2022; Ng Chok et al., 2018; Pung & Goh, 2017; Safari et al., 2022; Tuffour, 2022); cultural differences in the nursing role (Brunton & Cook, 2018; Brunton et al., 2019, 2020; Chun Tie et al., 2018; Kuzemski et al., 2022; Ng Chok et al., 2018; Safari et al., 2022), lack of support and appropriate orientation programs (Brunton et al., 2020; Chun Tie et al., 2018; Ng Chok et al., 2018; Pung & Goh, 2017; Safari et al., 2022) lack of appreciation and recognition of previous qualifications (Brunton & Cook, 2018; Chun Tie et al., 2018; Kim & Guo, 2021; Pung & Goh, 2017; Safari et al., 2022) barriers in career progression (Pendleton, 2017; Pung & Goh, 2017; Tuffour, 2022) and discrimination and racism (Brunton et al., 2020; Chun Tie et al., 2018; Pendleton, 2017; Safari et al., 2022; Tuffour, 2022).

As the proportion of IQNs in high-income countries continues to grow, a deeper understanding and respect for cultural backgrounds, beliefs, practices and communication styles will be required for locally qualified nurses (LQNs) and IQNs to work together in a professional and respectful environment. One strategy to achieve this is to promote intraprofessional cultural competence (IPCC).

While we have not been able to source a specific definition of IPCC, for the purpose of this study, the definition of cultural competence provided by Cross et al. (1989) will be adapted. Cultural competence is defined as '…a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations' Cross et al. (1989). With this in mind, IPCC is defined as: 'A set of congruent behaviours and attitudes that enable professionals to work respectfully and effectively in cross-cultural situations'. Increasing IPCC may increase collaboration, and enhance more positive intraprofessional relationships, improve work satisfaction and retention and may prevent practices linked to racism and discrimination in the work setting, especially between LQNs and IQNs.

It is important to notice that the concept 'cultural competence' was purposively selected over the concept of cultural humility. We are aware of the criticisms of cultural competence. However, the predominant focus of these critics lies in the delivery of care (Furlong & Wight, 2011; Herring et al., 2013; Isaacson, 2014; Kumagai & Lypson, 2009; Lekas et al., 2020; Stubbe, 2020). The concept of cultural competence was selected because this study examines the dynamics between nurses who share relatively equal power levels, focusing on their professional relationships and interactions and not in a care delivery encounter. The concept of 'competence' denotes the possession of skills, knowledge, or abilities essential for the effective performance of a task or a role. It can be cultivated through training and skill acquisition.

In contrast, the equally important but different concept of cultural humility is usually focussed on the power imbalance between healthcare providers and patients or students. Cultural humility is defined as 'a lifelong commitment to self-evaluation and critique, to redressing power imbalances… and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations' (Tervalon & Murray-García, 1998). It is a learning process that necessitates continuous dedication to introspection and self-assessment of one's actions, fostering personal growth (Chávez, 2018). A refined version of the theory aims to aid healthcare professionals in recognizing situations where they hold power over their patients or students and encourages them to embrace traits such as openness, self-awareness, humility and adaptability (Foronda et al., 2016).

Policies of regulatory bodies that guide the nursing profession may vary depending on the jurisdiction. Standards for practice (standards) and codes of conduct (codes) are commonly published by nursing regulatory bodies worldwide. The Standards signify the quality and achievement expected in actual nursing practice, serving as a benchmark for the nursing profession, governments and the public (Cashin et al., 2017). Standards are used by government bodies, regulatory authorities, educational institutions, employers and establish expectations within the nursing profession to delineate practice and conduct for regulatory purposes (Benton, 2011; Chiarella et al., 2008). They can be seen as a guide to what society (in the form of patients, families, colleagues or other health care workers) can expect from the registered nurse's (RN's) practice (Cashin et al., 2017). Additionally, the codes are thought to be baseline behavioural guidelines that nurses should demonstrate in

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every-day activities (Cowin et al., 2019). The primary focus of a Code is the individual practitioner, and it often includes rules, policies or regulations covering a wide range or areas such as patient care, professional relationships and scope of practice, among others. Codes serve as a set of standards against which individual behaviour can be measured and any breach could lead to disciplinary actions, either by the employer or the regulator (Staunton & Chiarella, 2019).

This study examines two sets of regulatory standards to explore the advice provided by nursing regulatory authorities regarding IPCC. The first set is the standards for practice from three jurisdictions: the United Kingdom, New Zealand and Australia. The second set is the codes of conduct developed by the regulatory authorities in these three jurisdictions.

2 | DATA SOURCES

The Standards sourced are: Future nurse: Standards of proficiency for registered nurses (2018) published by the Nursing and Midwifery Council of the UK (NMC, 2018a); the Competencies for Registered Nurses (2022) published by the Nursing Council of New Zealand (NCNZ, 2022), and the Nursing and Midwifery Board of Australia's (NMBA) Registered Nurse Standards for Practice (2016) and Nursing and Midwifery Board of Australia, 2016.

Additionally, the Codes of Professional Conduct of the regulatory authorities of the three countries are examined. These are The Code, Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates of the UK of the NMC (2018b); The Code of Conduct of the NCNZ (2012) and the Code of Conduct for Nurses of the Nursing and Midwifery Board of Australia (2018).

These three countries were selected as they have developed clear pathways for registration of IQNs (NCNZ, n.d.; Nursing and Midwifery Board of Australia, 2022; Nursing and Midwifery Council, 2023), In addition, all three countries rely heavily on the attraction and retention of IQNs (Marcus & Short, 2014; Scheffler & Arnold, 2019; Te Whatu Ora—Health New Zealand, 2023), and have high rates of migration (Organization for Economic Cooperation and Development, 2022). Consequently, their regulatory documents may (or may not) have content related to IPCC. The data collection was conducted by undertaking an online search of the publicly available documents on the official websites of the selected organisations.

Documents were read in full, and the Standards and Codes extracted into separate documents. As the data were freely available on the internet, permission to download and analyse was not required. For the data analysis, each document was examined using a thematic review process that sought to identify the elements of IPCC within the documents. The analysis was made using content analysis methodology, specifically semantic analysis or latent coding which looks to find implicit meaning in a specific text (Lawrence Neuman, 2021).

Based on the definition of IPCC provided in the introduction, a coding system consisting of four themes was established for the document analysis:

1) Theme one: content related to mutual collaboration and professional relationships.
2) Theme two: content referring to the prevention of racism and discrimination among nurses.
3) Theme three: content relevant to respecting values, attitudes and beliefs of colleagues that may differ across cultures.
4) Theme four: content referring to responding appropriately to cross-cultural interactions with colleagues.

The two contributing authors reviewed the first author's analysis of the documents for reliability and validity, and agreement was reached. The findings will hopefully be useful in the context of nursing practice in the United Kingdom, New Zealand and Australia and may be of value to other countries contemplating the need to strengthen intraprofessional cultural competence. However, it is recognised that this study has potential limitations. First, the findings may only be applicable to the specific context of nursing in these three countries, limiting their generalizability to other settings. Second, our personal perspectives as researchers may have influenced how we interpret content, although we have reflected on the latter risk as we have progressed our interpretation.

3 | FINDINGS

The findings are organised in two sections. First, each set of Standards is analysed in relation to the four themes, followed by each of the Codes. Only the parts of the documents relating to IPCC will be included in the text, although the references contain hotlinks to the full documents.

3.1 | Analysis of the standards of the United Kingdom, New Zealand and Australia

In this section, the Standards of the United Kingdom, New Zealand and Australia are analysed.

3.1.1 | Standards of proficiency for registered nurses, United Kingdom NMC

This document has seven platforms and two annexes (Table 1). Each platform contains outcomes relating to the expected nursing knowledge and skills for care to all individuals in any healthcare setting. The Standards reflect public expectations of the knowledge and skills expected to ensure safe, compassionate and efficient nursing care. The legal basis for the Standards is the Nursing and Midwifery Order 2001. The document identifies nurses as accountable professionals capable of autonomously or collaboratively, providing compassionate, evidence-based and person-centred care.

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TABLE 1 Structure of the nursing regulations from the United Kingdom, New Zealand and Australia.

The UK NMC standards of proficiency for RN Platforms	The NZNC competencies for RNs Competencies	The NMBA RN standards for practice Standards	The UK NMC code, professional standards of practice and behaviour Statements	The NZNC code of conduct Principles	The NMBA code of conduct for nurses Domains
Promoting health and preventing ill health. Assessing needs and planning care. Providing and evaluating care. Leading and managing nursing care and working in teams. Improving safety and quality of care. Coordinating care. Annexe A: Communication and relationship management skills. Annexe B: Nursing procedures.	Thinks critically and analyses nursing practice. Engages in therapeutic and professional relationships. Maintains the capability for practice. Comprehensively conducts assessments. Develops a plan for nursing practice. Provides safe, appropriate and responsive quality nursing practice.	Thinks critically and analyses nursing practice. Engages in therapeutic and professional relationships. Maintains the capability for practice. Comprehensively conducts assessments. Develops a plan for nursing practice. Provides safe, appropriate and responsive quality nursing practice.	Prioritise people. Practise effectively. Preserve safety. Promote professionalism and trust. Promote professionalism and trust.	Respect the dignity and individuality of health consumers. Respect the cultural needs and values of health consumers. Work in partnership with health consumers to promote and protect their well-being. Maintain health consumer trust by providing safe and competent care. Respect health consumers' privacy and confidentiality. Work respectfully with colleagues to best meet health consumers' needs. Act with integrity to justify health consumers' trust. Maintain public trust and confidence in the nursing profession.	Practice legally. Practise safely, effectively and collaboratively. Act with professional integrity and promote health and well-being.

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The outcomes of each platform will be analysed to examine the extent to which they reflect the four themes of IPCC.

Theme 1: Mutual collaboration and professional relationships

In this document, there are 11 outcomes and 11 skills in annexe A referring to communication, collaboration and relationships with people, their families, carers and colleagues.

The document includes content about effective communication (1.11) and maintaining appropriate relationships with colleagues (1.13). Annexe A.4 is focused on best practice communication skills and approaches for working with people in professional teams.

There is content related to collaboration and teamwork with other health professionals (1.18) and colleagues. Although the focus tends to be on leadership, working in teams, constructive feedback and team reflection (outcome 5), outcome 1.5 of the document encourages nurses to recognise vulnerability in themselves and in colleagues.

Outcomes that broadly refer to mutual collaboration and professional relationships are as follows:

- Understand the demands of professional practice and demonstrate how to recognize signs of vulnerability in themselves or their colleagues and the action required to minimise risk to health (1.5)
- Communicate effectively using a range of skills and strategies with colleagues and people at all stages of life and with a range of mental, physical, cognitive and behavioural health challenges (1.11)
- Demonstrate the skills and abilities required to develop, manage and maintain appropriate relationships with people, their families, carers and colleagues (1.13)
- Demonstrate the knowledge and confidence to contribute effectively and proactively in an interdisciplinary team (1.18)
- Understand the principles of effective leadership, management, group and organisational dynamics and culture and apply these to team working and decision-making (5.1)
- Understand and apply the principles of human factors, environmental factors and strength-based approaches when working in teams (5.2)
- Understand the principles and application of processes for performance management and how these apply to the nursing team (5.3)
- Exhibit leadership potential by demonstrating an ability to guide, support and motivate individuals and interact confidently with other members of the care team (5.6)
- Demonstrate the ability to monitor and evaluate the quality of care delivered by others in the team and lay carers (5.7)
- Demonstrate the ability to challenge and provide constructive feedback about care delivered by others in the team, and support them to identify and agree individual learning needs (5.9)

Annexe 4

4.1 Demonstrate effective supervision, teaching and performance appraisal through the use of:

- clear instructions and explanations when supervising, teaching or appraising others
- clear instructions and check understanding when delegating care responsibilities to others
- unambiguous, constructive feedback about strengths and weaknesses and potential for improvement
- encouragement to colleagues that helps them to reflect on their practice
- unambiguous records of performance

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4.2 Demonstrate effective person and team management through the use of:

- strengths based approaches to developing teams and managing change
- active listening when dealing with team members' concerns and anxieties
- a calm presence when dealing with conflict
- appropriate and effective confrontation strategies
- de-escalation strategies and techniques when dealing with conflict
- effective co-ordination and navigation skills through: appropriate negotiation strategies, appropriate escalation procedures, appropriate approaches to advocacy

Theme 2: Preventing racism and discrimination among nurses

There is only one outcome that refers to the ability to challenge discriminatory behaviour (1.4) in all care settings and areas of practice.

The outcome that refers to preventing racism and discrimination among nurses is as follows:

- Demonstrate an understanding of, and the ability to challenge, discriminatory behaviour (1.4)

Theme 3: Respecting values, attitudes and beliefs of colleagues that may differ across cultures

The document requires nurses to consider the 'diversity of values, belief and backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments' (1.14). We note however, that the text is exclusively oriented to the care of patients and does not mention cross-cultural considerations between colleagues.

- Provide and promote non-discriminatory, person-centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments (1.14)

The concept of 'culture' is also present in the introduction, where the role of the nurse in the 21st century is discussed. However, it is specific to the delivery of care, saying that 'nurses provide leadership in the delivery of care for people of all ages and from different backgrounds, cultures and belief'.

Theme 4: Responding appropriately to cross cultural interactions with colleagues

The Standards do not address how to communicate appropriately in cross-cultural situations with colleagues.

3.0.1 | Competencies for Registered Nurses of the NZNC

This document outlines the skills and activities expected in the work setting and comprises four domains (see Table 1). The 20 competencies across four domains are described with indicators to guide professional judgement. The Competencies for RNs also address particular roles such as management, education, policy and research. The text indicates that nurses play a crucial role in healthcare, utilizing their knowledge and judgement to assess health needs, deliver care and guide individuals in managing their well-being. Their practice encompasses diverse settings, involving collaboration with healthcare teams and adherence to legislative requirements and established standards.

Theme 1: Mutual collaboration and professional relationships

This document specifically emphasises effective communication with colleagues (3.3). The relevant indicators underscore the importance of employing effective communication techniques, utilizing appropriate language in various contexts and facilitating time for meaningful discussions. Additionally, for nurses in roles related to management, education, policy and research, there are two distinct competencies centred on the establishment and maintenance of effective interpersonal relationships.

The document also includes a competency (2.8) encouraging nurses to engage with more experienced colleagues for feedback on

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their practice. Another focuses on the maintenance of professional development (2.9), with two indicators explicitly guiding nurses on providing support, guidance and teaching to their colleagues.

Domain 4, which refers to interprofessional healthcare and quality improvement, has a competency valuing collaboration with colleagues and the healthcare team.

Competencies that refer to mutual collaboration and professional relationships are as follows:

Competency 2.8 Reflects upon, and evaluates with peers and experienced nurses, the effectiveness of nursing care.
Competency 2.9 Maintains professional development.

- Indicator: Contributes to the support, direction and teaching of colleagues to enhance professional development.
- Indicator: Takes responsibility for one's own professional development and for sharing knowledge with others.

Competency 3.3 Communicates effectively with health consumers and members of the health care team.

- Indicator: Uses a variety of effective communication techniques.
- Indicator: Employs appropriate language to context.
- Indicator: Provides adequate time for discussion.
- Indicator: Endeavours to establish alternative communication methods when health consumers are unable to verbalise.
- Indicator: Accesses an interpreter when appropriate. Competencies for nurses involved in management, education, policy and research:
- Establishes and maintains effective interpersonal relationships with others, including utilising effective interviewing and counselling skills and establishing rapport and trust.
- Communicates effectively with members of the health care team, including using a variety of effective communication techniques, employing appropriate language to context and providing adequate time for discussion.

Competency 4.1 Collaborates and participates with colleagues and members of the health care team to facilitate and coordinate care.

- Indicator: Provides guidance and support to those entering as students, beginning practitioners and those who are transferring into a new clinical area.
- Indicator: Collaborates with the health consumer and other health team members to develop plan of care.

Theme 2: Preventing racism and discrimination among nurses

The text contains a competency concerning culturally safe practice, but it focuses on the patient. There is no reference to the prevention of racism and discrimination between colleagues.

Theme 3: Respecting values, attitudes and beliefs of colleagues that may differ across cultures

Within Domain 4, Competency 4.2 specifically directs healthcare practitioners to recognise and value the roles and skills of all team members. Competency 1.5 refers to cultural safety, primarily in relation to care delivery. There is no guidance on addressing diverse values, attitudes and beliefs within the workplace.

The competencies that mention respect for values, attitudes, beliefs and more that may differ across cultures are as follows:

Practises nursing in a manner that the health consumer determines as being culturally safe (1.5)

Indicators:

- Applies the principles of cultural safety in own nursing practice.
- Recognises the impact of the culture of nursing on health consumers' care and endeavours to protect the health consumer's wellbeing within this culture.

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- Practises in a way that respects each health consumer's identity and right to hold personal beliefs, values and goals.
- Assists the health consumer to gain appropriate support and representation from those who understand the health consumer's culture, needs and preferences.
- Consults with members of cultural and other groups as requested and approved by the health consumers.
- Reflects on their own practice and values that impact on nursing care in relation to the health consumer's age, ethnicity, culture, beliefs, gender, sexual orientation and/or disability.
- Avoids imposing prejudice on others and provides advocacy when prejudice is apparent.

Recognises and values the roles and skills of all members of the health care team in the delivery of care (4.2)

Indicators:

- Contributes to the co-ordination of care to maximise health outcomes for the health consumer.
- Collaborates, consults with and provides accurate information to the health consumer and other health professionals about the prescribed interventions or treatments.

Theme 4 responding appropriately to cross-cultural interactions with colleagues

We note there is no reference to this theme in this document.

3.0.1 | Registered nurse standards for practice of the NMBA

The NMBA RN Standards are applicable to RNs nationally and consist of seven standards explained in detail in Table 1. Specific criteria outline how each standard should be demonstrated. These criteria can be understood within the framework of each individual RN's professional practice.

RNs' practice in Australia is characterised by a person-centred and evidence-based approach, encompassing preventive, curative, formative, supportive, restorative and palliative elements. RNs are expected to engage in therapeutic and professional relationships with individuals, families, groups and communities in a wide range of clinical settings and roles. The document acknowledges the cultural and linguistic diversity within the Australian society and the impact of history and culture on the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

Theme 1: Mutual collaboration and professional relationships

Standard two refers to engaging in therapeutic and professional relationships, including collegial generosity. It promotes trust and respect in professional relationships.

The document refers to the importance of fostering 'a culture of safety and learning' and collaborative practice with 'health professionals and others' (2.7 and 2.8). Although it does not refer to other nurses directly, they would seem to be included in this general description.

Also, there is content that refers to promoting a culture of safety and learning with the health care team to share knowledge that supports the well-being of patients (2.7).

Standard 3.3 identifies collaborative practice that promotes the use of lifelong learning to support self and others' professional development.

Standards that mention mutual collaboration, and professional relationships are as follows:

- Actively fosters a culture of safety and learning that includes engaging with health professionals (2.7)
- Participates in and/or leads collaborative practice (2.8)
- Uses a lifelong learning approach for continuing professional development of self and others (3.3)

Theme 2: Preventing racism and discrimination among nurses

There is no reference to the prevention of racism or discrimination in this document.

Theme 3: Respecting values, attitudes and beliefs of colleagues that may differ across cultures

Respect for other cultures and experiences is mentioned explicitly in one standard (1.3).

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Standards that mention respecting values, attitudes, beliefs and more that differ across cultures are as follows.

- Respects all cultures and experiences, which includes responding to the role of family and community that underpin the health of Aboriginal and Torres Strait Islander peoples and people of other cultures (1.3)

Theme 4: Responding appropriately to cross cultural interactions with colleagues

There is one standard referring to communicating effectively and respecting the dignity, culture, values, beliefs and rights of people during nursing practice (2.2). Even though the standard does not directly mention colleagues, the term 'during nursing practice' suggests that nursing colleagues would be involved.

The standard that refers to responding appropriately to cross cultural interactions with colleagues is as follows:

- Communicates effectively, and is respectful of a person's dignity, culture, values, beliefs and rights (2.2)

3.1 | Codes of professional conduct for nurses from the United Kingdom, New Zealand and Australia

This completes the analysis of the three Standards against the identified themes. We turn now to examine the Codes from the three selected jurisdictions.

3.1.1 | The UK MC Code, professional standards of practice and behaviour for nurses, midwives and nursing associates

This document contains the NMC expectations of conduct and behaviour that nurses, midwives and nursing associates must uphold. It is mandated that individuals practising as nurses in the United Kingdom must be on the NMC register.

The Code consists of 25 statements divided into four main groups (see Table 1). It outlines the professional standards, conduct and behaviours expected of those on the NMC register, providing clear guidance applicable in diverse practice settings. The Code reflects the expectations of patients and the public. It seeks to serve as a focus for professional reflection and provides evidence of continued competence, ensuring safe and effective practice and it emphasises the RN's commitment to upholding these requirements, with consequences for serious breaches that includes removal from the register.

The statements of the Code can be applied in diverse practice settings, are not negotiable and cannot be used discretionally.

Theme 1: Mutual collaboration and professional relationships

This theme contains three statements describing effective communication with colleagues (7.1, 8.2, 8.3).

- Use terms that people in your care, colleagues and the public can understand (7.1)
- Maintain effective communication with colleagues (8.2)
- Keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff (8.3)

It contains a whole statement dedicated to working co-operatively (8). This statement is specific to respecting the skills, expertise, and contribution of colleagues, as well as supporting them in cases of performance issues (8.1, 8.7).

- Respect the skills, expertise and contribution of your colleagues, referring matters to them when appropriate (8.1)
- Be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety (8.7)

Statement 9 refers to sharing skills, knowledge and experience with colleagues.

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- Provide honest, accurate and constructive feedback to colleagues (9.1)
- Gather and reflect on feedback from a variety of sources, using it to improve your practice and performance (9.2)
- Deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times (9.3)
- Support students' and colleagues' learning to help them develop their professional competence and confidence (9.4)

Theme 2: Preventing racism and discrimination among nurses

Statement 17 states to protecting vulnerable people or those who may be at risk. However, the focus is on patients and the public in general and does not specifically mention colleagues.

Statement 20.2 requires the nurse to avoid discrimination, bullying and harassment.

Also statement 20.3 requires the nurse to have awareness of how behaviours may affect or influence others.

Similarly, statement 20.7 warns against expressing personal beliefs (political, religious or moral) to other people inappropriately. These statements are broader than those relating to theme 1 and are oriented towards patients, other healthcare professionals and the general public.

- Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection (17)
- Act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment (20.2)
- Be aware at all times of how your behaviour can affect and influence the behaviour of other people (20.3)
- Make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way (20.7)

Theme 3: Respecting values, attitudes and beliefs of colleagues that may differ across cultures

Although the Code does not provide any specific instructions regarding respect for culturally driven values, attitude, and beliefs, statement 9.3 advises nurses to respect views and opinions in a professional way.

- Deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times (9.3)

Theme 4: Responding appropriately to cross cultural interactions with colleagues

The Code makes no reference to responding appropriately to cross cultural interactions. It only states that it is the responsibility of the nurse 'to communicate clearly and effectively in English' (7.5).

- Be able to communicate clearly and effectively in English (7.5)

3.0.1 | The Code of Conduct of the NZCN

The NZNC, is responsible for overseeing the practice of nurses with the primary aim of safeguarding the health and safety of the public. The NZNC Code of Conduct outlines the ethical standards expected of nurses, complementing other legal obligations from the Health and Disability Commissioner and the Health Information Privacy Code. It serves as a benchmark for evaluating nurses' behaviour, and failure to meet these standards may lead to disciplinary proceedings. It also provides instructions about the provision of culturally appropriate nursing services for the Maori population.

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The NZNC Code of Conduct comprises eight principles, (Table 1) which will be now analysed in light of the themes of this study. Specific standards outline how each principle should be demonstrated.

Theme 1: Mutual collaboration and professional relationships

Principle 6 is focused on collaboration and respect among colleagues. It has standards regarding respect (6.1 and 6.2), and collaboration (6.1, 6.6 and 6.7), recognition of each other's experience and expertise (6.2) and effective, respectful and clear communication with other nurses (6.3).

- Treat colleagues with respect, working with them in a professional, collaborative and co-operative manner. Recognise that others have a right to hold different opinions (6.1)
- Acknowledge the experience and expertise of colleagues, and respect the contribution of all practitioners involved in the care of the health consumer (6.2)
- Communicate clearly, effectively, respectfully and promptly with other nurses and health care professionals caring for the health consumer and when referring or transferring care to another health professional or service provider (6.3)
- Work with your colleagues and your employer to monitor the quality of your work and maintain the safety of those in your care (6.6)
- Support, mentor and teach colleagues and other members of the health care team, especially students and those who are inexperienced (6.7)

Theme 2: Preventing racism and discrimination among nurses

The Code has three standards that go some way to addressing this theme (6.4, 6.5 and 6.9). Standard 6.4 explicitly addresses 'dismissiveness, indifference, bullying, verbal abuse, harassment or discrimination' towards colleagues. It also forbids this sort of behaviour in public places and on social media.

The standards are focused on avoiding 'malicious or unfounded criticisms' (6.5) and zero tolerance for 'unsafe, incompetent, unethical or unlawful practice', encouraging to report it to whom it may concern (6.9).

- Your behaviour towards colleagues should always be respectful and not include dismissiveness, indifference, bullying, verbally abuse, harassment or discrimination. Do not discuss colleagues in public places or on social media. This caution applies to social networking sites, e.g. Facebook, blogs, emails, Twitter and other electronic communication mediums (6.4).
- Health consumers' trust in the care of colleagues or health providers should not be undermined by malicious or unfounded criticisms you make (6.5).
- Intervene to stop unsafe, incompetent, unethical or unlawful practice. Discuss the issues with those involved. Report to an appropriate person at the earliest opportunity and take other actions necessary to safeguard health consumers (6.9).

Theme 3: Respecting values, attitudes and beliefs of colleagues that may differ across cultures

Principle 2 focusses on respect for patients' cultural backgrounds but does not mention colleagues.

There is also content regarding cultural safety (1.5), avoiding discrimination based on 'ethnicity, religion, gender, sexual orientation, political or other opinion, disability or age' (1.6) and imposing political, religious or cultural views (1.8), but all of them are focused on patients and families, not on the relationships with colleagues.

- Treat health consumers as individuals and in a way they consider to be

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culturally safe (see Guidance: cultural safety) (1.5)

- Practise in a way that respects difference and does not discriminate against those in your care on the basis of ethnicity, religion, gender, sexual orientation, political or other opinion, disability or age (1.6)
- Do not impose your political, religious and cultural beliefs on health consumers, and intervene if you see other health team members doing this (1.8)
- Respect the cultural needs and values of health consumers (principle 2)

Theme 4: Responding appropriately to cross cultural interactions with colleagues

The content regarding responding to cross-cultural interactions (principles 1 and 2) again only focusses on health consumers. Additionally, The Code includes a guide for cultural safety in nursing practice also focused on the delivery of care.

Principle 1: Respect the dignity and individuality of health consumers

Principle 2: Respect the cultural needs and values of health consumers

3.0.1 | The Code of Conduct for Nurses (The Code) of the NMBA

The NMBA Code serves as a guide outlining legal requirements, professional behaviour and conduct expectations applicable to all nurses across various practice settings. It explains the principles of professional behaviour essential for safe practice and explicitly defines the expected conduct of nurses within their professional community and the broader society. The document comprises seven principles of conduct organised into four domains (See Table 1). It aligns with the National Law (NMBA, 2018) and provides guidance for their application in various contexts of nursing practice. Emphasising the first duty of nurses to prioritize the interests of people, it underscores the importance of safe and effective practice. The applicability of the Code extends to all types of nursing practice, encompassing both clinical and nonclinical roles, paid or unpaid.

The NMBA Code also outlines the consequences of failure to adhere to its principles, which may result in registration issues and be considered as unsatisfactory professional performance, unprofessional conduct or professional misconduct. While serving as a valuable resource for fostering professionalism in the Australian health system, it emphasizes that it does not substitute other legal requirements outlined in the National Law, legislation or case law, and compliance with all NMBA Standards, Codes and guidelines is imperative. The terms 'Person or people' are employed significantly to denote individuals who have engaged in a therapeutic and/or professional relationship with a nurse.

Theme 1: Mutual collaboration and professional relationships

Regarding this theme, the document has guidance on creating a positive work environment that support the rights, dignity and safety of people, including colleagues (3.2.f). Additionally, it underscores the significance of clear and accurate communication with colleagues (3.3 d).

Create a positive, culturally safe work environment through role modelling, and supporting the rights, dignity and safety of others, including people and colleagues (3.2.f)

Clearly and accurately communicate relevant and timely information about the person to colleagues, within the bounds of relevant privacy requirements (3.3 d)

Theme 2: Preventing racism and discrimination among nurses

The NMBA Code requires nurses to respect diversity and avoid bias, discrimination and racism based on gender, disability, race, ethnicity, religion, sexuality, age or political beliefs (3.2d).

Principle 3.4 refers to bullying and harassment, is clear in not tolerating or engaging in such behaviour (3.4.a), recognizing different forms of bullying and discrimination (3.4.b), avoiding and reporting any discriminative behaviour (3.4.d and e) and the use of social media to engage in these situations (3.4.c).

- Adopt practices that respect diversity, avoid bias, discrimination and racism, and challenge belief based upon assumption

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(e.g., based on gender, disability, race, ethnicity, religion, sexuality, age or political beliefs) (3.2.d)

- Never engage in, ignore or excuse such behaviour (3.4 a)
- Recognise that bullying and harassment takes many forms, including behaviours such as physical and verbal abuse, racism, discrimination, violence, aggression, humiliation, pressure in decision-making, exclusion and intimidation directed towards people or colleagues (3.4 b)
- Understand social media is sometimes used as a mechanism to bully or harass, and that nurses should not engage in, ignore or excuse such behaviour (3.4 c)
- Act to eliminate bullying and harassment, in all its forms, in the workplace (3.4 d)
- Escalate their concerns if an appropriate response does not occur (3.4 e)

Theme 3: Respecting values, attitudes and beliefs of colleagues that may differ across cultures

The content about respecting cultures, beliefs, gender identities, sexualities and experiences are explicit and refers to people and to colleagues (3.2.a, b, d, and f).

- Understand that only the person and/or their family can determine whether or not care is culturally safe and respectful (3.2 a)
- Respect diverse cultures, beliefs, gender identities, sexualities and experiences of people, including among team members (3.2 b)
- Adopt practices that respect diversity, avoid bias, discrimination and racism, and challenge belief based upon assumption (for example, based on gender, disability, race, ethnicity, religion, sexuality, age or political beliefs) (3.2 d)
- Create a positive, culturally safe work environment through role modelling, and supporting the rights, dignity and safety of others, including people and colleagues (3.2 f)

Theme 4: Responding appropriately to cross cultural interactions with colleagues

There is content that addresses the need to support the rights, dignity, and safety of others (including colleagues) (3.2.f) and to support and foster an inclusive, positive, and culturally safe work environment (3.2.e and f). There is also mention of cultural safety regarding person(s) and families (3.1).

- Provide care that is holistic, free of bias and racism, challenges belief based upon assumption and is culturally safe and respectful for Aboriginal and Torres Strait Islander peoples (3.1 a)
- Support an inclusive environment for the safety and security of the individual person and their family and/or significant others (3.2 e)
- Create a positive, culturally safe work environment through role modelling, and supporting the rights, dignity and safety of others, including people and colleagues (3.2 f)

4 | DISCUSSION

We analyse the findings now in terms of the four intraprofessional cultural competence criteria, initially in relation to the professional standards and then for the codes of conduct. First, the theme 'Mutual

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collaboration, and professional relationships' is referred to in all six of the regulatory documents. A closer analysis of the documents from the UK NMC shows the importance of effective communication, collaboration and teamwork within the professional settings. Specifically, in the NMC Standards of Proficiency for RN, there is a strong emphasis on effective communication, cooperation and sharing experiences with colleagues.

The NZNC publications explicitly refer to mutual respect, collaboration and effective communication, including in interactions with colleagues, to ensure a positive work environment, quality work and patient safety. The NMBA RN Standards for Practice underscore the importance of engaging in therapeutic and professional relationships and emphasising collegial generosity. Finally, the NMBA Code of Conduct for Nurses outlines the importance of engaging in effective, clear and accurate communication with colleagues, as well as contributing to the establishment of a positive work environment. The fact that these publications include intraprofessional collaboration is relevant to the nursing profession, because research has shown its positive impact on nursing practice. For instance, it is linked to factors like job satisfaction and retention (Ulrich et al., 2019), a high quality of care (Schön Persson et al., 2018; Ylitörmänen et al., 2023) and improving team cohesion, a good working environment and wellbeing (Ylitörmänen et al., 2023). Additionally, placing an emphasis on communication is not only relevant for quality of care, patient safety, or avoiding a patients' death (Raeisi et al., 2019), but it becomes particularly important in the interaction of multicultural teams. There is evidence that the interactions between LQNs and IQNs are typically brief, goal-oriented, and often lack mutual informal or interpersonal components regardless of whether their first language is English (Brunton & Cook, 2018; Brunton et al., 2019; Dywili et al., 2021; Mapedzahama et al., 2018; Philip, Woodward-Kron, & Manias, 2019; Philip, Woodward-Kron, Manias, & Noronha, 2019).

Second, racism, discrimination, bullying and harassment are commonly reported in clinical work settings in nursing practice (Brathwaite, 2018; Hilario et al., 2018). It is acknowledged that these practices may take different forms, involving verbal, physical, social or psychological abuse by another person or group of people at work (Australian Human Rights Commission, 2011). While none of the Standards for Practice explicitly addresses the theme of 'preventing racism and discrimination', the issues of bullying and harassment are addressed to varying degrees within the Codes of Conduct in each of the three countries.

The sources of racism, discrimination, bullying and harassment against IQNs may vary from nursing colleagues, staff members, patients and visitors (Joseph et al., 2022; Philip, Woodward-Kron, & Manias, 2019; Philip, Woodward-Kron, Manias, & Noronah, 2019) (Dywili et al., 2021; Mapedzahama et al., 2018). They can be expressed in the form of direct confrontations, staff insubordination, limited professional development opportunities (Dywili et al., 2021), adversarial interactions among colleagues or exclusionary behaviours (Parke et al., 2023).

The UK NMC Standards of Proficiency for RN mention the requirement to challenge discriminatory behaviours in all care settings and areas of practice, however, this is not specifically applied to relationships with colleagues. The UK NMC Code, Professional Standards of Practice and Behaviour address the protection of vulnerable individuals or those at risk, also without explicitly mentioning colleagues. It emphasises the importance of maintaining appropriate conduct to avoid discrimination and harassment and prohibits the expression of personal beliefs (political, religious or moral) to other people inappropriately. These points by contrast are oriented to patients, other health care professionals and the general public. Particularly in the United Kingdom, racism and discrimination have been a serious matter within the society (Brathwaite, 2018; Equity and Human Rights Commission, 2016; West et al., 2017) and in the National Health Service (NSH) (National Health Service, 2023). In the nursing work setting in the UK racism, discrimination, bullying and harassment have been reported to be problematic issues (Mcilroy, 2022; West et al., 2017). For instance, about 30% of nurses reported they had suffered bullying or harassment from colleagues based on age, ethnicity, gender, disability and sexuality in 2021 (Mcilroy, 2022). It would be beneficial to have clearer content or guidance in both the Standards for Practice and the Code of Conduct regarding fostering a culturally inclusive and respectful environment within the nursing profession itself.

In the NZNC Competencies for Registered Nurses there is no mention of the prevention of racism and discrimination among colleagues. The Code is clear about the requirement for cultural safety, but it is specifically oriented to the delivery of care. Cultural safety is a concept that originated in the context of providing care to indigenous populations and it acknowledges that certain groups, such as indigenous peoples or marginalised communities, may experience systemic discrimination and power imbalances within healthcare systems (Curtis et al., 2019; Kaphle et al., 2022). Cultural safety aims to establish settings where every individual feels secure, valued and empowered to utilize healthcare services without concern for prejudice or exclusion, thus focusing on the patient or client (Kaphle et al., 2022). Conversely, the NZNC Code of Conduct explicitly outlines the expected respectful behaviour toward colleagues, emphasizing a zero-tolerance approach to dismissiveness, bullying and discrimination.

The NMBA RN Standards for Practice lack any explicit mention of prevention of racism or discrimination. The absence of specific references to the relationship between colleagues may suggest a gap in addressing these critical issues within the professional context. However, the NMBA Code of Conduct, which was developed after the Standards for Practice, is explicit in the requirement to prevent racism and discrimination among nurses, emphasizing the importance of respecting diversity and steering clear of bias based on various factors. Notably, the subtheme 3.4 addresses bullying and harassment, elucidating the imperative for nurses to abstain from engaging in or tolerating such behaviours. This theme reflects a comprehensive stance against discriminatory practices, including a recognition of the varied forms such behaviours can take, from physical and verbal

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abuse to racism and exclusion. The text establishes clear expectations for nurses to act proactively to eliminate bullying and harassment, reinforcing the broader commitment to a respectful and inclusive professional environment. As flagged, the NMBA Code of Conduct (2018) was published 2 years after the RN Standards for Practice (2016), perhaps indicating a growing awareness of the problem by 2018.

It is possible that the detailed approach taken by the NMBA Code of Conduct for Nurses could be attributed to the prolonged existence of issues concerning racism, discrimination, bullying and harassment. However, even though the NMBA Code of Conduct for Nurses is clear about these issues, the literature shows that these such behaviours are frequently cited as barriers that affect the professional integration of IQNs in Australia (Dywili et al., 2021; Joseph et al., 2022; Mapedzahama et al., 2018; Philip, Woodward-Kron, & Manias, 2019; Philip, Woodward-Kron, Manias, Noronha, 2019; Zanjani et al., 2021). Moreover, a 2019 report by the NSW Nurses and Midwives' Association (NSWNMA) revealed that approximately 25% of respondents encountered racial discrimination on a monthly basis. Surprisingly, only 31% of these incidents were formally reported (The New South Wales Nurses and Midwives' Association, 2019). Other studies have shown that everyday racism in the workplace has been naturalised and socially accepted (Dywili et al., 2021; Mapedzahama et al., 2018). These findings are at odds with the stipulations of the NMBA Code of Conduct, potentially highlighting a disconnection between regulatory frameworks and their effective implementation in nursing practice. This revelation underscores the persistence of such behaviours within the professional environment, despite existing regulations expressly prohibiting them. Consequently, further research is required to understand the factors contributing to this dissonance and to inform potential interventions aimed at fostering a workplace environment where nondiscrimination occurs. We recognize discrimination, racism, bullying and harassment are multifaceted and complex phenomena. While codes of conduct and standards for practice provide a foundational framework, collective action from various stakeholders will be required to address them, including nursing managers, nursing unions, educational providers and individual professional commitment to self-training in IPCC.

It is noteworthy that regulations in Australia and New Zealand encompass provisions related to cultural safety. This aspect holds particular relevance for the healthcare approach towards the health care users from disadvantaged or disempowered social groups, especially the indigenous populations of both countries. The percentage of aboriginal population in Australia is 3.8% (Australian Bureau of Statistics, 2023), while in New Zealand they comprise 17.3% of the national population (Ngā Tūtohu Aotearoa—Indicators Aotearoa New Zealand Government, 2023).

The UK NMC Standards of Proficiency for RN mandate that nurses consider the 'variety of values, beliefs, and backgrounds, cultural attributes, language needs, and preferences, considering any necessary adjustments'. Notably, the text only focuses on the care of patients without explicit reference to colleagues. Conversely, The UK NMC Code, Professional Standards of Practice and Behaviour explicitly discusses respect for the views and opinions of colleagues.

The NZNC Competencies for Registered Nurses acknowledge the importance of recognising and valuing the roles and skills of team members, but there is a gap in explicitly addressing the importance of respecting values, attitudes, beliefs and the cultural backgrounds of colleagues. Principle 2 of the NZNC Code of Conduct is entirely focused on respecting patients' cultural backgrounds, but there is a notable absence of guidance regarding relationships with colleagues in this context.

The NMBA RN Standards for Practice acknowledge the importance of respecting values, attitudes and beliefs that differ across cultures, particularly emphasizing the health of Aboriginal and Torres Strait Islander peoples and individuals from diverse cultural backgrounds. The standards do not distinctly specify colleagues or patients, but they do clarify that the term 'person' is inclusive of both categories. The NMBA Code of Conduct for Nurses highlights the respect for cultures, beliefs, gender identities, sexualities, and experiences and there is explicit acknowledgement of the relevance of these principles to colleagues. The emphasis on creating a positive, culturally safe work environment through role modelling underscores the commitment to support the rights, dignity and safety of both patients and colleagues.

Surprisingly, neither of the UK NMC documents directly addresses the crucial aspect of responding appropriately to cross-cultural interactions with patients or colleagues. Moreover, both documents fall short in explicitly acknowledging and providing guidance on interactions with colleagues from culturally and linguistically diverse backgrounds. In the UK NMC Code, Professional Standards of Practice and Behaviour the responsibility for effective communication in English is mandated, without consideration for the importance of intraprofessional communication. In a country where there is a high proportion of immigrants in the entire population, and which has been a historical destination for IQNs (Brathwaite, 2018), and where the percentage of IQNs is 15.1%, it is surprising that the nursing regulations do not address responding appropriately to cross-cultural interactions.

The NZNC Competencies for Registered Nurses do not include content about interactions in cross-cultural situations, and in the NZNC Code of Conduct this content is exclusively focused on patients. There is an opportunity to enhance the NZNC guidelines by emphasising the importance of respecting colleagues' diverse cultural backgrounds and practice in cross-cultural situations.

Lastly, The NMBA Code of Conduct for Nurses addresses the need to respond appropriately to cross-cultural interactions with colleagues. Although the text predominantly focuses on cultural safety for patients and families, there is an inclusion of principles supporting the rights, dignity and safety of colleagues. The NMBA Code of Conduct for Nurses demonstrates a comprehensive approach to nursing practice, emphasizing mutual collaboration, the prevention of discrimination, respect for cultural differences and the creation of a positive and inclusive professional environment for both patients and colleagues. Although the term Intra-Professional

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Cultural Competence is not explicitly used, the essence of interprofessional collaborative care is encapsulated in the principles of domain 3. The NMBA Code of Conduct for Nurses has the most comprehensive and complete approach of the three documents regarding intraprofessional cultural competence.

Enhancing the visibility and emphasis of IPCC within nursing regulation may require the incorporation of IPCC as a core principle and the use of explicit language and guidance that highlight its importance. Achieving this goal would require collaboration with educational providers, nursing professional organizations and employers, among others. Intraprofessional cultural competence is understood as the basic skills, knowledge, or abilities that nurses need to demonstrate to work respectfully and effectively in cross-cultural situations. In nursing, failure to adhere to IPCC within the workplace can result in detrimental consequences for patients and the overall quality of care. Therefore, IPCC should be considered an obligation and a fundamental standard. It also provides a basic benchmark for professionals who may be resistant to learning from others or engaging in lifelong self-reflection but are required to work in multicultural teams.

Standards for Practice establish expectations for professional nursing practice, while Codes of Conduct are considered mandatory behavioural requirements within the nursing profession. Thus, there is a need for greater specificity in these regulations to underscore the necessity of IPCC. This specificity should extend to providing explicit guidance on recognizing and addressing behaviours that require the application of IPCC. To enhance awareness and incorporation of IPCC principles, strategic initiatives must be undertaken. For instance, public campaigns should be employed to increase overall awareness of IPCC. Additionally, the dissemination of information about IPCC should be amplified across nursing education programs, with a particular emphasis on clinical placements. While Bachelor of Nursing training typically incorporates content related to cultural competence and cultural safety, the challenge lies in translating this knowledge into practical applications within professional relationships, through the implementation of IPCC. Standards and Codes can be seen as tools to effectively address racism only if their significance is emphasised, adherence to their guidelines is closely monitored, and breaches result in tangible consequences. Further research is required to determine the effective strategies and propose a comprehensive action plan that involves the clinical setting, managers, unions and educational providers.

5 | CONCLUSION

Given the increasing cultural diversity in the nursing workforce, reinforcing the need for regulatory content that more adequately addresses intraprofessional cultural competence is crucial, especially for countries with a high proportion of internationally qualified nurses, such as the United Kingdom, New Zealand and Australia. Better integration of locally qualified and internationally qualified nurses may have a positive impact on mutual collaboration, better communication and prevention of situations associated with racism, discrimination, bullying and harassment.

The contribution of this paper to the nursing literature rests on proposing a strategy to increase awareness and to tackle conduct related to racism, discrimination, bullying and harassment in nursing practice. This strategy is the introduction of IPCC. This research may be useful for nursing education, regulation and practice, supervisors and managers, nursing policy makers and nursing educators, IQNs, LQNs, the public and patients. The role of regulation is crucial in changing the culture of nursing practice. Increasing IPCC would be also beneficial for patient-centred care and would build more inclusive work environments.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available in Future nurse: Standards of proficiency for registered nurses at https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf. NZ Competencies for Registered Nurses at https://nursingcouncil.org.nz/Public/NCNZ/nursing-section/Registered_nurse.aspx. Registered nurse standards for practice at https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx. The Code, Professional standards of practice and behaviour for nurses, midwives and nursing associates of the United Kingdom at https://www.nmc.org.uk/standards/code/#:~:text=The%20Code%20presents%20the%20professional,and%20promote%20professionalism%20and%20trust. The Code of Conduct of the NZNC at https://www.nursingcouncil.org.nz/Public/Nursing/Code_of_Conduct/NCNZ/nursing-section/Code_of_Conduct.aspx. Nursing and Midwifery Board of Australia (2018). Code of Conduct for Nurses at www.nursingmidwiferyboard.gov.au.

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5.5 Literature update since article publication

The documents analysed for this publication have not been updated since the article's original publication.

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Chapter Six

Study Four: What are the views of educational and regulatory experts in relation to the elements of intra-professional cultural competence (IPCC) in Australia? What are the experiences of the elements of IPCC in one school of nursing in relation to educational preparation and clinical practice?

6.1 Introduction

Nursing education is a multifaceted process that relies on the critical contributions of educational and regulatory experts, academics and clinical educators, amongst others, to shape the future generations of nurses. The role of health professional regulators focuses (*inter alia*) on establishing regulatory documents (often called standards) that apply nationwide. These regulatory documents provide a framework that defines expectations for nursing practice and professional conduct, guiding nurses in their daily activities (Cashin et al., 2017; Cowin et al., 2019; Staunton & Chiarella, 2024). They also serve as benchmarks for evaluating individual behaviour, with breaches potentially leading to disciplinary action by employers or regulatory bodies (Staunton & Chiarella, 2024). Nurse academics play a pivotal role in shaping the professional identity of undergraduate nursing students due to their consistent and sustained contact with them and their role modelling for them throughout the students' studies (Baldwin et al., 2017). This role modelling may occur in every interaction they have with their students, influencing students' knowledge, attitudes, behaviours and professional development (Baldwin et al., 2017). The clinical facilitator's role is distinct from both academic and clinical roles. It encompasses guiding students in applying nursing theory to practice, tracking their progress, addressing any learning challenges, and working closely with clinical staff and faculty to ensure effective student support (Sweet & Broadbent, 2017).

As previously discussed, the prevalence of practices linked to racism, discrimination, bullying and harassment in nursing remains high in the Australian context (Correa-Betancour, Marcus, et al., 2024; Chun Tie et al., 2018; Dywili et al., 2021; Hartin et al., 2018; Mapedzahama et al., 2018; Parke et al., 2023; Zanjani et al., 2021). Bachelor of Nursing (BN) curricula, guided by the Registered Nurse (RN) Accreditation Standards, include content on cultural competence (Australian Nursing and Midwifery Accreditation Council [ANMAC], 2019). Regulatory documents governing professional nursing practice, such as the *Code of Conduct for Nurses* (Nursing and Midwifery Board of Australia [NMBA], 2022) and the *Registered nurse Standards for Practice* (NMBA, 2016), also incorporate elements designed to prevent and address these behaviours. Additionally, Australian laws, including the Racial Discrimination Act 1975 *(Racial Discrimination Act 1975* [Cth]) and the Fair Work Act 2009 *(Fair Work Act 2009* [Cth]), regulate such practices in the workplace. Despite these measures, such practices are reported to persist. Therefore, there appears to be a gap between academic content, regulatory documents and laws, and the reality of everyday nursing practice.

A possible strategy to address these issues in nursing practice and educate nurses could be the use of intra-professional cultural competence (IPCC). This is a concept developed as part of this research, based on the definition of cultural competence coined by Cross et al. (1989): "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enable that system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13). Building on this concept of cultural competence, this thesis proposes intra-professional cultural competence (IPCC) to be defined as "a set of congruent behaviours and attitudes that enable professionals to work respectfully and effectively in cross-cultural situations" (Correa-Betancour, Chiarella, & Short, 2024). A more detailed analysis of the concept of IPCC in Three - the examination of regulatory documents- led to the identification of four core elements:

1. Mutual collaboration and professional relationships;
2. Prevention of racism, discrimination, bullying and harassment among nurses;
3. Respecting values, attitudes and beliefs of colleagues that may differ across cultures; and
4. Responding appropriately to cross-cultural interactions with colleagues.

Study Four aimed to explore the views of educational and regulatory experts in relation to the elements of IPCC in Australia, and to analyse the experiences of the elements of IPCC in one school of nursing in relation to educational preparation and clinical practice.

6.2 Methods

The methods for Study Four are described in detail in Chapter Two.

6.3 Results from experts, academics and clinical educators

6.3.1 Demographic characteristics

The study included three sets of interviews (Appendix A). The first set was with the experts group, consisting of three participants. The second set of interviews was with academics who teach content related to cultural competence at the selected university. There were two academics, both females, both Australian-born, with no experience studying or working overseas, with one identifying as Aboriginal. The third set of interviews was with clinical educators who worked casually for the selected school of nursing. A total of nine clinical educators were recruited, comprising seven female and two male participants. Five of the clinical educators were internationally qualified nurses (IQNs) with a culturally and linguistically diverse (CALD) background. All participants had more than 10 years of professional experience. The demographics of the regulatory and educational experts, academics and clinical educators are presented in Table 6.1.

The results of the interviews will be presented in the three following sections:

> 6.3.2 Views about the experiences of the elements of IPCC in relation to educational preparation and clinical practice: **Experts' views**
>
> 6.3.3 Experiences of the elements of IPCC in one school of nursing in relation to educational preparation and clinical practice: **Academics' views**
>
> 6.3.4 Experiences of the elements of IPCC in one school of nursing in relation to educational preparation and clinical practice: **Clinical educators' views**.

Table 6.1. Participant demographics

Number	Gender	Years of experience	Qualifications	Country of birth	Country of qualification	Years in Australia	Background	Aboriginal background	Years in the current role
Regulatory and educational experts									
1	Female	26	BN MSc (Nurs) Postgraduate certificate in teaching and learning in higher education PhD in nursing	Australia	United Kingdom	N/A	Caucasian	No	N/A
2	Male	45	Certificate in general nursing BA (Hons) Graduate diploma in legal practice	Australia	Australia	N/A	Caucasian	No	N/A
3	Female	>40	Hospital certificate in general nursing Hospital certificate in midwifery BN Postgraduate diploma in nursing practice for aged care Masters in nursing	Australia	Australia	N/A	Caucasian	No	N/A

Number	Gender	Years of experience	Qualifications	Country of birth	Country of qualification	Years in Australia	Background	Aboriginal background	Years in the current role
Academics									
1	Female	18	Registered nurse BN (Hons, 1st Class) Graduate certificate in diabetes education and management PhD	Australia	Australia	N/A	Aboriginal and Torres Strait Islander	Yes	Four years
2	Female	38	Registered nurse MHlthSc (Ed) BHlthSc (Nurs) DipAppSc (Nurs) TESOL certificate Graduate certificate in linguistic research PhD in applied linguistics	Australia	Australia	N/A	Caucasian	No	10 years

Number	Gender	Years of experience	Qualifications	Country of birth	Country of qualification	Years in Australia	Background	Aboriginal background	Years in the current role
Clinical educators									
1	Male	16	BN (Lebanon) Graduate certificate in nursing leadership and management (Australia) Diploma in training and assessment (Australia) Diploma in curriculum design and development (Australia) Honours research project	Lebanon	Lebanon Australia	9 years	CALD	No	7 years
2	Male	16	BN (Philippines) MNurs in clinical education (Australia) PhD (Australia)	The Philippines	The Philippines Australia	12 years	CALD	No	9 years
3	Female	>20	BSc (Nurs) (Philippines) Registered to work in Philippines, Singapore, Malaysia, New Zealand and Australia	The Philippines	The Philippines	10 years	CALD	No	14 years
4	Female	>35	BN (Australia) Midwifery (England)	Malaysia	Australia England	30 years	CALD	No	32 years

Number	Gender	Years of experience	Qualifications	Country of birth	Country of qualification	Years in Australia	Background	Aboriginal background	Years in the current role
5	Female	36	BN Certificate in nursing Intensive care nursing Counselling, creativity counselling Psychotherapy and psychodrama Certificate IV in training and assessment	Australia	Australia	N/A	Caucasian	No	11 years
6	Female	>20	General trained nurse Intensive care certificate Midwifery Perioperative nursing Graduate diploma in nurse education Master of clinical studies	Australia	Australia	N/A	Caucasian	No	11 years
7	Female	25	Disability care worker Enrolled nurse Registered nurse	Australia	Australia	N/A	Caucasian	No	9 years
8	Female	>15	BPhysio (The Philippines) BN (The Philippines) Bridging course for registration in Australia	The Philippines	The Philippines Australia	16 years	CALD	No	11 years

Number	Gender	Years of experience	Qualifications	Country of birth	Country of qualification	Years in Australia	Background	Aboriginal background	Years in the current role
9	Female	43	Registered nurse Midwifery Cardiothoracic nursing Administration	Australia	Australia	N/A	Caucasian	No	20 years

BA = Bachelor of Arts; BHlthSc (Nurs) = Bachelor of Health Science (Nursing); BN = Bachelor of Nursing; BPhysio = Bachelor of Physiotherapy; BSc (Nurs) = Bachelor of Science (Nursing); CALD = culturally and linguistically diverse; DipAppSc (Nurs) = Diploma of Applied Science (Nursing); Hons = Honours; MHlthSc (Ed) = Master of Health Science (Education); MNurs = Master of Nursing; MSc (Nurs) = Master of Science (Nursing); N/A = not applicable; PhD = Doctor of Philosophy; TESOL = Teaching English to speakers of other languages

6.3.2 Views about the experiences of the elements of IPCC in relation to educational preparation and clinical practice: Experts' views

The experts' views were organised into two main themes (Table 6.2):

a. Culture in the clinical setting; and
b. Fostering the elements of IPCC.

Table 6.2. Experts' views: themes and subthemes

a) **Culture in the clinical setting**	i. Recognising the existence of racism and discrimination and/or bullying and harassment	
	ii. Diversity in the clinical setting	
b) **Fostering the elements of IPCC**	i. Fostering the elements of IPCC in universities	
	ii. Fostering the elements of IPCC through regulations	- Regulatory and implementation challenges - Practical application and implementation of regulations - Cultural competence and professional development
	iii. Fostering the elements of IPCC in healthcare organisations	

a) Culture in the clinical setting

The theme "Culture in the clinical setting" refers to the contextual characteristics that exist in the clinical setting in Australia. It is divided into two subthemes (Table 6.2):

i. Recognising the existence of racism and discrimination (R&D) and/or bullying and harassment (B&H); and
ii. Diversity in the clinical setting.

i. Recognising the existence of R&D and/or B&H

Regarding **recognising the existence of R&D and/or B&H**, Experts 1 and 3 acknowledged that racism, discrimination, bullying and harassment are widespread issues within the nursing profession, extending beyond cultural differences. Expert 3 considered social class as a potential contributing factor influencing workplace dynamics.

> "It's mentioned around, you know, the topics of bullying within the profession are quite prevalent and not limited, unfortunately, they're not limited to cultural differences." (Expert 1)

The **global prevalence of bullying in nursing** was highlighted, noting that it is a widespread issue across the discipline of nursing, not limited to Australia. According to Expert 1, discrimination can also originate from **other healthcare professionals**. They observed a perceived hierarchy within the healthcare field, where nursing is often regarded as having a lower status compared to other professions, and there may also be discrimination and bullying by senior nurses towards recently graduated nurses. They also commented that students, particularly those from international or CALD backgrounds, could experience racism during their clinical placements, compounded by a lack of support, insufficient mentoring and instances of discrimination.

> "So, I know that it's an issue there [in the UK, New Zealand and Saudi Arabia] as well. And just knowing the literature, it seems to be a cultural issue within our profession." (Expert 1)
>
> "There's a lot of ageism within our profession as well, and young nurses are often subject to poor behaviours from their seniors as well." (Expert 1)

Expert 1 highlighted a discrepancy between education and practice, observing **a discrepancy between what is taught in educational settings** – such as best practices and professional standards – and what students experience in the workplace. They believed that **students often replicate behaviours** associated with racism, discrimination, bullying and harassment when in clinical settings.

> "And that goes back to Kath Melia's work in the 80s around that socialisation of students into the workplace and how what you teach them might be the best, but they go out and quite quickly become socialised into some of those poor cultures." (Expert 1)
>
> "And it's difficult because we can address this in the undergraduate program, but then the students go out into a work culture which is not good practice." (Expert 1)

The experts suggested several strategies that may help to prevent situations related to **R&D and/or B&H.** For example, they mentioned the benefits of having a multicultural academic staff mix that may offer students role models who reflect their own cultural backgrounds and experiences, mirroring the diversity of both the student body and society (Expert 1). The impact of **organisational size** on tolerance and inclusivity was another strategy suggested. It was posited that smaller settings may offer a more intimate and controlled atmosphere, which might diminish the visibility or impact of these challenges (Expert 2).

> **"**I think just because healthcare is so diverse, I think the smaller organisational settings, there's obviously more tolerance and the sorts of issues [in the literature] are probably less problematic, in my view. But that probably is just contextual in the smaller, you know, the organisational factor, rather than that anyone has any better skills or understanding of the issues. So, it might have a more positive outcome, but it's by default rather than planning." (Expert 2)

Expert 2 also acknowledged the **need for clear, practical and specific interventions** to address these issues. Rather than generalising or assuming consensus, they advocated for a detailed examination and open discussion to develop effective strategies for improvement.

> "Because I think we make assumptions that everyone nods when you talk about, you know, lack of support and whether it's unconscious or intentional, whether it's aggressive behaviour from LQNs [locally qualified nurses] to, you know, … IQNs. That's the real issue, because I think if there's more time spent spelling that out in terms of its problem operations and what can be done practically to minimise or eliminate, that's where you'll get some results." (Expert 2)

ii. Diversity in the clinical setting

Experts agreed that the **nursing workforce is diverse**. The **evolution of workforce diversity** over the past 20 years was acknowledged (Expert 3). However, they also emphasised that, despite the progress made, there was still substantial work to be done to achieve true diversity and the elements of IPCC in the healthcare workforce.

> "Whereas 20 years ago, that was very different, very different. So, I don't think, I think we've got an enormous amount of work to do. So, I'm really welcoming of the research that you're undertaking, but I do think the pendulum is sort of starting to go in the right direction." (Expert 3)

Regarding IQNs, they recognised that IQNs face multiple challenges, particularly the often poorly understood cultural differences they encountered and expected in their professional environments.

The importance of empathy and understanding was highlighted (Expert 2). However, an **increase in acceptance of nurse diversity was observed**, which may be attributed to a healthcare workforce that increasingly reflects the diversity of the community it serves (Expert 3).

> "If I was in Shenzhen or something in China, you know, out of your depth, I couldn't even imagine how I'm trying to run around a ward with those language complexities, even if I'd undertaken some very basic, you know, Cantonese or Mandarin type language skills. But you've also highlighted the cultural differences, and I think they're poorly understood in terms of what different IQNs expect and experience from their cultures in respect of both the provision of care and the interaction with their professional colleagues or even superiors. So that is very easily misinterpreted, and, you know, often negatively for both parties, you know, the IQN and the LQN." (Expert 2)
>
> "Like, you do see them, but, you know, they're different and they're not as many. So, people are more accepting because the workforce is looking more like what the community looks like." (Expert 3)

b) Fostering the elements of IPCC

The theme "Fostering the elements of IPCC" has three subthemes (Table 6.2):

i. Fostering the elements of IPCC in universities;

ii. Fostering the elements of IPCC through regulations; and

iii. Fostering the elements of IPCC in healthcare organisations.

i. Fostering the elements of IPCC in universities

The experts believed that the elements of IPCC could be fostered in universities through the content organisation in the BN curriculum, through their academics and the students. The three experts provided their opinions about how the elements of IPPC could be fostered through the **content organisation of the BN curriculum**. They acknowledged the variability in the effectiveness of implementation across institutions, but also observed a strong commitment among educators and professionals to advancing the elements of IPCC within the healthcare sector (Expert 3).

> "But some universities obviously do it better than others. And I think there's a very strong desire and well, I personally think there's the intra professional (sic) that needs to happen so that how we practise and that's shared." (Expert 3)

All three experts agreed on the **need for consistent integration of the elements of IPCC, diversity and inclusivity in the curriculum**. While the current curriculum includes principles of diversity, culture, inclusion and cultural safety, it does not fully address the specific needs of the elements of IPCC (Expert 2). Furthermore, this integration is inconsistently applied, often appearing in a "patchy" manner across different institutions in Australia (Expert 1). Expert 3 reinforced this view, emphasising that educational practices are increasingly focusing on the importance of nurses being culturally competent, not only with patients, but also in their interactions with colleagues. However, **gaps in the implementation of IPCC elements** were identified.

> "Yeah, because I do think it's patchy [the curriculum] the way it's done. You know, I don't think all of the curricula across Australia might be doing it all as well. So, I think we do need to have more emphasis on it [elements of intra-professional cultural competence]." (Expert 1)
>
> "I think the statement could be sufficient to address the needs of intra-professional cultural competence, I think it could, because it's a principle, it's an expectation. I think how it's applied may not be there yet. And it goes back to my first comment around the catch-up piece." (Expert 3)

The **evolving approach to cultural competence** in nursing education was acknowledged (Expert 1 and 3). Early efforts tended to focus broadly on multiculturalism, but over time, this has expanded to include specific attention to First Nations peoples and other distinct cultural groups. The importance of adopting a strengths-based approach in cultural education, similar to that used in Aboriginal and Torres Strait Islander cultural education, was emphasised (Expert 1).

> "I think before, with cultural competence, whether it be diverse, you know, sort of multicultural, which is where people started and then the First Nations and then we tended to separate out." (Expert 3)
>
> "And it's similar to the Aboriginal and Torres Strait Islander cultural education in the way that what we need to check in our curriculum as well is that we are applying a strengths-based approach to the different cultures and not stereotyping cultures, making sure that we're making sure that we are taking an evidence based, an evidence-based approach and a strengths-based approach." (Expert 1)

Expert 3 believed that educators play a crucial role in guiding students, helping them develop critical thinking skills and a deeper understanding of the complexities of healthcare practice.

> "There needs to be a lot done because I think, do you know, one of the good things that's starting to happen, and I think this is where nurse or any educators, but nurse education could make a difference, because if you actually superimpose those dimensions [differences in communication patterns, cultural differences in the nursing role and intra-professional discrimination and racism] on every activity you do, whether it's a direct clinical task, whether it's an application of care delivery, whether it's how the interprofessional team works together to deliver a service, there really should be a lens." (Expert 3)

Expert 3 also acknowledged the importance of **student feedback in accreditation**. They considered that talking to students provided valuable insights into how the curriculum is experienced, including the clarity and effectiveness of teaching on professional standards like the NMBA Code of Conduct.

> "And so, unless you go looking and think about it, you wouldn't know. Does that make sense?

> But the fact that accreditors go in and assess not only the curriculum and go and talk to students and get feedback, and I'm often at the other end of that, you know, with my university partners, I do believe that we've come a long way in that area." (Expert 3).

Expert 1 held a **critical view on how an academic's characteristics can enhance or promote** the elements of **IPCC**. They opined that, although diversity exists within academic teams, they believed it was not sufficiently visible at higher levels of academia, suggesting the presence of barriers to advancement. They advocated for a proactive approach to fostering a more inclusive and equitable academic environment, where diversity is reflected not only at entry levels, but across all ranks and positions.

> "I think what I'm trying to do in my own department as well is look at how my staff from different backgrounds are promoted through the system as well, because I do think in academia, while we have that diversity in the academic team, it's not represented at the higher levels of academia." (Expert 1)

It was posited that students' characteristics may play a role in fostering the elements of IPCC. There has been an increasing diversity among nursing students in recent years, which is a key feature and strength of the academic environment, enhancing the learning experience and cultural competence (Experts 1 and 3).

> "Our students themselves, as I've said, although there's 23% that are international students, I would say you're probably looking at about 70% of our students are culturally and linguistically diverse. It's huge. And my staff are also, you know, so that is a key feature of our diversity." (Expert 1)
>
> "I'm, you know, they are truly amazing nurses, truly amazing, and they come from different ethnic and cultural backgrounds. We're seeing the most diverse in the last five to 10 years than I have seen in a 45-year nursing career." (Expert 3)

The need to **educate all students on respectful behaviours and practices** that contribute to creating a culturally safe environment in healthcare settings was acknowledged (Expert 1).

> "So, I think we do need to teach all students, particularly those who are not from culturally and linguistically diverse backgrounds, you know, how to be respectful and how to operate in a culturally safe way." (Expert 1)
>
> "But also, when we've got people from cultural and linguistically diverse backgrounds, we also need to support them to be able to work within a culturally safe way within Australia as well, you know, while supporting their own." (Expert 1)

For students and staff who engage in religious practices, the current curriculum and academic calendar were_considered to be inadequate (Expert 1). For example, challenges in balancing academic responsibilities with religious observances could negatively impact students' integration into the broader university community. The importance of developing inclusive policies that accommodate a wide range of religious practices was also highlighted (Expert 1).

> "One of my students is from Pakistan, and they're one of our student leaders, and they were on placement during Ramadan. You know, and when our students are out on placement, they're also still trying to do some academic work at the same time. And that's incredibly stressful for students who are fasting to be able to do that work whilst, you know, they're completely fasting. And our curriculum doesn't support that. It just doesn't support that. And also, the way of the academic calendar, it doesn't support my academic staff, you know, because I have some academic staff who also observe Ramadan." (Expert 1)

ii. Fostering the elements of IPCC through regulations

According to the participating experts, the elements of IPCC could be fostered through regulations. Specifically, this could be achieved by identifying regulatory and implementation challenges, ensuring the practical application and implementation of regulations, and cultural competence and professional development.

Regulatory and implementation challenges

Expert 2 acknowledged the **difficulty of achieving and implementing uniform change** across a diverse and widespread country. For instance, they acknowledged the inherent challenges in setting and applying standards within the BN curriculum. They stated that the **NMBA standards**

are necessary to establish a baseline for educational quality and professional practice, but they are not sufficient on their own to address all issues.

> "Setting standards and applying standards is an imprecise science, you know, and regulatory bodies, you know, I've spent my life in global regulation and my preference is what I call light touch regulation" (Expert 2)
>
> "You can get some real change at micro level in various communities across the country. But if you're looking at a systematic change across the country, you're probably not going to achieve it. It's just too hard." (Expert 2)
>
> "Now, this is one where the context doesn't work it out for itself. But the standard setting and what's imposed on other educational institutions, or we'll talk later about the NMBA code, they're necessary but not sufficient." (Expert 2)

Expert 2 acknowledged challenges of **auditing standards in education and enforcement in educational accreditation**. They considered that the process of ensuring compliance through audits is both time consuming and costly, which can be a significant burden for educational institutions and regulatory bodies. They thought that punitive enforcement, such as strict audits and penalties, may not necessarily lead to improvements in how educational institutions implement standards.

> "So, the challenge is always, you know, one, it's time consuming and very expensive to audit." (Expert 2)
>
> "It's difficult for a regulator to continue to go in there and with the big stick and hit them over the head and tell them they're not doing it well enough." (Expert 2)
>
> "Even if you did that, putting aside the time and the expense, it doesn't mean they're going to do it any better than they're currently doing." (Expert 2)

Concerns were raised that achieving compliance with standards or receiving **accreditation often does not translate into meaningful progress** or change (Experts 2 and 3). One of the reasons proffered was that, during program evaluations and reviews, **educational providers may receive approval or accreditation by merely demonstrating that they have addressed certain standards** on a surface level. It was felt that a **flexible and supportive approach** from regulators, one that

emphasises guidance and partnership rather than strict enforcement, may be useful to address this situation (Experts 2 and 3).

> "You can still meet a standard, but not have an outcome. Yeah. So, I'd love to say, I'd love, well, I'd love to have a magic bullet." (Expert 3).
>
> "When programs are reviewed and evaluated, they get the magic tick whenever the educational provider or the practitioner, if you want to move on to the Code, can show they've done something to meet that standard." (Expert 2)
>
> "And I think it is about sometimes being a bit kind to ourselves in curriculum design, or actually, you know, I don't even understand why universities and partners like ourselves can't work out what does that look like? How could we work better together?" (Expert 3).

Expert 3 recognised the **interpretations and applications of the NMBA Code of Conduct can evolve**, particularly as new issues or areas of concern emerge within the profession. They recognised the evolving acceptance of First Nations' perspectives, particularly due to the inclusion of a statement in the Code of Conduct. While they noted that full integration or substantial progress has not yet been achieved, they believed there has been a significant shift in perception.

> "And also, the Code of Conduct, often that doesn't change that much. It's what sits behind it. You know what I mean? And that interpretation or how we bring in, for example, bullying and harassment wasn't always there." (Expert 3).
>
> "We were talking about the Code of Conduct, but it was very much about the First Nations statement, which was very controversial at the time. Very controversial. And now it is, we may not have integrated or achieved a lot, but people would go, well, you could not have it." (Expert 3)

Practical application and implementation of regulations

It was observed that the NMBA can play a pivotal role in disseminating consistent messages to its extensive network of practitioners, particularly in reinforcing the importance of cultural awareness and understanding. It was stressed that recommendations should go beyond general suggestions and **provide clear, practical steps** that can be applied in everyday practice (Expert 2).

> "And academics are very good at making suggestions, but often they're not realistic. So, I just put that on the table … But you need to then be quite specific, I think, in terms of how does that play out? And then once you've explained that in quite … I think, in a lot of detail, then you say how it can [it] be done better, how it can be minimised or eradicated or whatever, eliminated." (Expert 2)
>
> "But I don't think there's anything wrong with the NMBA attempting to use its educational muscle across its half a million practitioners to get those messages over time, just to continue to reinforce the same message about cultural competence and understanding the differences that practitioners have, and how that potentially impacts on the clinical interface with patients." (Expert 2)
>
> "That would be more meaningful because it's not as if anyone would not identify the issues raised or see that they're genuine issues of concern. But most people don't think about them, you know." (Expert 2)

Cultural competence and professional development

The importance of **clearly describing the various forms** in which racist behaviour can manifest in the workplace or educational settings was emphasised. It was suggested that clear, precise descriptions of issues are crucial for developing effective solutions and recommendations (Expert 2). An increase in the reporting of issues related to R&D and/or B&H may suggest a **greater awareness and understanding** of the elements of IPCC (Expert 3).

> "So, although, again, it might seem trite, I think you need to spell out how racism or racist behaviour, how it manifests, and how that can be minimised or eliminated." (Expert 2)
>
> "Look, again … I think there needs to be a far greater level of specificity about what the problems are and what can be done to go forward." (Expert 2)
>
> "Because why I know that is because we do a lot of organisational cultural surveys and these are sort of some of the questions, not nursing. Well, we can pull out nursing and midwifery, but there's more reported. But I think people are aware, so they report. And we all tell people that's a positive thing." (Expert 3).

The importance of the elements of IPCC in both education and regulation was recognised (Experts 2 and 3). It was felt that the current cultural **competence frameworks** are clear and well defined in Codes of Conduct and professional standards (Expert 3).

> "But they reflect the Code of Conduct, too, of course, and our standards. So, I think that they aren't there yet. But that statement facilitates, you know, is very open-ended on how our tertiary partners may want to apply that." (Expert 3).
>
> "But I do think that is broad enough. The intent is very clear, very clear. I don't think you could be clearer. And I have no vested interest in this because we don't write these standards. We only get consulted on them." (Expert 3).

The evolution and progress of nursing and **the Code of Conduct** was observed (Expert 3). It was commented that, while significant progress has been made, there is still some work to do to reach desired goals.

> "I could actually talk them through how the Code of Conduct, in many iterations from when I was a baby nurse, so over 45 years, I could tell them what it started out as and what it's come to." (Expert 3)
>
> "Absolutely nowhere near where we need to be. But have we come a long way? I guess because I've lived the history, I can see it and I can feel it … even though I'm saying things are better, they're not, they've got, my goodness, we've got a long way to go." (Expert 3)

iii. Fostering the elements of IPCC in healthcare organisations

It was suggested that fostering the elements of IPCC in healthcare organisations could be achieved through several key strategies (Experts 1 and 3). To begin with, improving workplace culture to positively impact retention and satisfaction, addressing bullying and harassment, ensuring psychological safety, promoting cultural competence and reflective practice, and supporting the development of professional identity and adaptation in nursing. **Workplace culture** might be a significant factor contributing to the premature departure of experienced nurses (Expert 1).

> "You know, how can we improve the workplace culture so that we can attract people and that we can retain them? … Because we've got experienced nurses who are leaving the profession way earlier than retirement age because of a number of factors. But workplace culture is definitely one of them." (Expert 1)

The inclusion of cultural competence and reflective practice was suggested as essential for fostering the elements of IPCC within healthcare organisations (Experts 1 and 3). Experts emphasised the importance of a commitment to ongoing self-reflection, practising cultural competence, understanding personal biases, learning from others, and developing strategies for more inclusive and empathetic care (Experts 1 and 3). Reflective practice and critical thinking were recognised as crucial components in shaping professional identity and enhancing the quality of care delivered.

> "And then if you've got the lens of cultural capability and how that applies and if you're providing person-centred care, how can that not apply." (Expert 3)
>
> "I think it is the, that's what makes a professional is a perfect, is that reflective practice and critical thinking and then the application of that and what that means to the practice that we're delivering." (Expert 3)

6.3.3 Experiences of the elements of IPCC in one school of nursing in relation to clinical practice and educational preparation: Academics' views

The interviews with academics led to three main themes (Table 6.3):

a. Culture in the clinical setting;

b. Educational preparation; and

c. Australian culture.

Table 6.3. Academics' experiences: themes and subthemes

a) **Culture in the clinical setting**	i. Recognising the existence of racism and discrimination and/or bullying and harassment
	ii. Diversity in the clinical setting
b) **Educational preparation**	i. Academics' and students' characteristics
	ii. BN curriculum
	iii. Recognising the existence of racism and discrimination and/or bullying and harassment
c) **Australian culture**	i. Diversity of the Australian society
	ii. Prevalence of racism and discrimination and/or bullying and harassment in society (not in hospitals)

a) Culture in the clinical setting

The first theme, "Culture in the clinical setting", explores the contextual characteristics present within clinical environments in Australia. Two subthemes were identified (Table 6.3):

i. Recognising the existence of racism and discrimination (R&D) and/or bullying and harassment (B&H); and
ii. Diversity in the clinical setting.

i. Recognising the existence of R&D and/or B&H

Regarding the first subtheme, both academics acknowledged the existence of both R&D and/or B&H in the clinical setting. It was observed that R&D and/or B&H can manifest in **various forms**. For instance, Academic 1 mentioned accent-related discrimination from patients towards nurses who spoke with a different accent, and racism from patients, particularly noting that it was more prevalent among older patients.

> "You know, I've got colleagues that have got quite heavy accents, and patients are quite dismissive of this one particular colleague that I've got … Definitely, you get racism from patients, especially older patients." (Academic 1)

The phenomenon of **cultural clustering**, where nurses from similar cultural or ethnic backgrounds tend to work together in specific wards or departments, was observed (Academic 1). While it was acknowledged that the formation of informal groups could significantly influence workplace interactions and dynamics, it might also serve as a strategy to help prevent R&D and/or B&H in nursing.

> "Yeah, I think it's also [contributing factors to avoid this racism discrimination], I know I worked on a respiratory ward and there was lots and lots and lots of Filipino nurses too. So, I think you also get clustering as well." (Academic 1)
>
> "So, there's some really, really interesting dynamics, I think, that goes on in wards where you've got high numbers of, and they're not, and don't get me wrong, they're not all internationally qualified. They're just from, a lot of them are born in Australia, but come from specific, you know, ethnic and cultural backgrounds, if that makes sense." (Academic 1)

Both academics thought that **racism in the workplace was becoming more covert or subtle**, rather than overt, but still impactful. Such discrimination may not be immediately visible, especially to those who do not directly experience it.

> "So, yeah. But so, yeah, so the [name] hospital where I work at, but not to say that there isn't racism. I think, though, it's becoming more underground, less overt. Not so much for First Nations, though." (Academic 1)

Both academics acknowledged the **challenges and issues IQNs encounter**, both as reported in the literature and observed in clinical practice. For example, one academic mentioned a lack of sufficient mentoring and support from supervisors, particularly for "non-white" staff, that may contribute to slower **career progression** and less investment in their professional development. It was suggested that Caucasian nurses tended to be promoted more quickly and received greater investment in their professional development compared to their "non-white" counterparts. This

may be evident in the lack of diversity in leadership positions, with one of the academics suggesting that most clinical nurse managers (NUMs) were "white", despite the diversity within the nursing staff.

> "One of the things that I've actually witnessed, I think in, when I was working in intensive care, was I think there is sometimes a lack of education and promotion opportunities for internationally qualified nurses … and even local, I think there's this kind of subtle discrimination that occurs where white nurses do get promoted more rapidly or are more invested in." (Academic 1)
>
> "And if I think about this particular ward that I worked on, most of the clinical NUMs were white, you know, despite the fact that there was a very, very diverse group of nurses." (Academic 1)

Academic 1 proposed that significant **changes in cultural competency and inclusivity** within healthcare settings may take time, potentially spanning generations. They felt that newer generations were becoming more open and less prejudiced, reflecting a generational shift towards greater acceptance and reduced racism compared to their predecessors.

> "Yeah, I think something generational, something that it can be changing through the years, but it will take time. It is, and I do have, and that's completely right about that sort of, that generational influence. I feel like the new generations now are much more accepting and a lot less racist than their predecessors and just little things, you know, like gay marriage was passed in Australia, you know, a few years back." (Academic 1)

ii. Diversity in the clinical setting

The diversity in the clinical setting is mostly due to patients' and nurses' characteristics. Academic 1 suggested that experiences and challenges related to cultural competence, support and integration could vary significantly depending on the location, reflecting the demographic characteristics of each area.

> "Somebody's saying, well, you know, we have a lot of white patients, and I thought, oh, not where I work, you know? So, I think it's very geographical as well. I think it's, if you just sort of examine specific areas, then you're going to get very, very different takes." (Academic 1)

Academic 1 believed that the diversity in the clinical setting could affect interactions and perceptions within the healthcare environment. They suggested that cultural attributes, like direct communication, could lead to misunderstandings. Although these differences were often not meant to be offensive, they could be perceived negatively due to a lack of cultural understanding.

> "Language proficiency and difference in, definitely differences in communication patterns. I find that some people from some cultures can be quite blunt." (Academic 1)
>
> "And so, they don't, you know, that they don't mean anything by it. It's kind of like a cultural attribute, if you like, but people can be very put off by it, because they don't understand that it's not meant in the way that they're, you know, that's communication difficulties, where there's those misunderstandings, you know." (Academic 1)

b) Educational preparation

This theme has three subthemes (Table 6.3):

i. Academics' and students' characteristics;

ii. BN curriculum; and

iii. Recognising the existence of R&D and/or B&H.

i. Academics' and students' characteristics

The diverse **cultural backgrounds of nursing students** were acknowledged, recognising that they brought their own unique cultural perspectives and experiences to the learning environment (Academic 1). One academic was of the view that **academics at this university were predominantly** Caucasian, contrasting with more diverse workplaces and highlighting the varying levels of diversity across different institutions and locations (Academic 1). In contrast, Academic 2 pointed out the presence of First Nations lecturers at the institution, suggesting an effort to diversify the faculty and integrate Indigenous perspectives into the academic setting.

> "I think the other thing that people tend to forget as well is that so many of our students are either international or come from culturally diverse backgrounds as well. So, they bring their own, you know, their own sort of understanding and their own culture into the room as well." (Academic 1)
>
> "And because I work in [name] Uni, it's a predominantly a very white space. You know, I've got a few colleagues, I think they're all, I think they're all qualified here, though, and born here, but from, you know, diverse backgrounds. But it's very, very white." (Academic 1)

ii. BN curriculum

Academic 2 expressed confidence about the **sufficiency of the curriculum content** to address the elements of IPCC. They expressed the hope that the approach to cultural competence taught in the curriculum was consistently upheld by the staff. In the **BN curriculum**, the elements of IPCC were reinforced using different strategies. First, it was noted that the ANMAC regulatory requirements ensured that nursing students received education specific to **First Nations' health** (Academic 1). The integration of this content was throughout the nursing curriculum and a standalone subject. Secondly, it was also addressed through the existence of other subjects covering cultural content and, finally, this content was often reinforced through examples and discussions.

> "I think that the content in the curriculum is sufficient to address the needs of intra-professional cultural competence so, yeah. As I said, it's across the curriculum, and we teach quite specifically around racism within those subjects that I mentioned, so I would hope, so I think in terms of the content, it's there, so I would hope that that approach is across the staff as well." (Academic 2)
>
> "We talk about, you know, here's the example of West African people migrating here. You know, sudden increase in like diabetes and cardiovascular disease, the same for Indian people. So, culture's kind of like touched on a lot, but I don't know that that's specifically written into the curricula." (Academic 1)

Academic 1 commented that **simulation scenarios** are also used to reinforce content related to cultural capability. For instance, simulated patients are identified as being from various cultural

backgrounds, including Aboriginal or CALD, to reflect real-world diversity. Content on gender diversity and trans experiences is also included.

> "So, every week they have a different patient from a different background. So, I was saying, you know, with week one, we've got respiratory. So, we've got a young Korean non-binary person that's got asthma. They're 17. They're vaping." (Academic 1)

It was suggested that strategically embedding culturally relevant content and practices throughout the educational **curriculum** would strengthen the elements of IPCC (Academic 1).

> "One of the things that I really believe in is what I call seeding the system." (Academic 1)

The **school's strategic commitment to anti-racism** was highlighted by Academic 2, indicating that it was a key focus in the school's strategic action plan, which might distinguish it from other institutions.

> "In terms of the school and its approach, it's included in the strategic action plan of the school, and the school's taking an anti-racism stance, so they're trying to actively work against racism, so there's certainly that focus from a school strategic perspective." (Academic 2)

Another strategy identified to foster the elements of IPCC in the nursing curriculum involved **creating intentional opportunities for cultural discussions** and ensuring a safe space for open dialogue. Academic 1 shared their own positionality, including aspects of identity such as race, gender and cultural background, to encourage and enrich these discussions. The importance of encouraging students, particularly Caucasian students, to **reflect on their own privilege and the societal structures** that were predominantly designed by and for Caucasian individuals was highlighted. Finally, the importance of making students understand **diverse perspectives**, particularly those from dominant cultural backgrounds, to understand and appreciate diverse perspectives and worldviews was discussed (Academic 1).

> "So, we have lots of opportunities to sort of talk about culture and things … by having these open conversations with students, I think create like that sort of safe space." (Academic 1)
>
> "And so, that is working on our students, you know, making them reflect and making, in particular, white students because it's not that they're specifically racist. It's not that they're, you know what I mean, but they're just blinded by the fact that the world is designed for them by white people. Do you know what I mean?" (Academic 1)
>
> "And they don't kind of understand how it could be different. So, trying to get them to understand other people's point of view and world views … so, I feel like we'll get there, that, you know, that by the time our students go out that they will have a little bit more insight." (Academic 1)

Academic 1 acknowledged that some students and staff may initially be **hesitant to engage** in discussions or activities around sensitive or potentially uncomfortable topics. Then, as a strategy, they might use **provocative and relatable questions** to engage students in discussions. Additionally, the importance of **training staff to facilitate sensitive conversations** was observed (Academic 1).

> "And we do sexuality. I remember talking doing this sexuality tutorial. And I had this lovely little table of Nepalese and Indian students, and they were horrified, you know, and they're like, we don't we didn't even talk about this before we got married. You know what I mean? Like marriage was a surprise to them, you know, so and that was a really wonderful conversation that we had in the class." (Academic 1)
>
> "I don't know how you teach staff to do that kind of relational stuff or have those conversations if they're not comfortable or, you know, because there's a cultural element to that as well." (Academic 1)

Despite the efforts to educate about R&D and/or B&H in the educational setting, Academic 1 described the phenomenon where new graduates may quickly adapt to the existing culture of the ward or institution where they begin working.

> "It's hard though, because what happens is they quickly become enculturated into whatever the culture of the ward is where they go to work. It's very, very, I think it's very hard to resist. So, especially if they're moving into, you know, mostly white institutions, it's never questioned." (Academic 1)

A **critical view of the accreditation process**, particularly regarding the evaluation of educational content and the integration of cultural and Indigenous perspectives, was expressed by Academic 1. **Limitations** in the accreditation process were identified, suggesting that it was possible to craft accreditation documents in a way that satisfied requirements without truly addressing the underlying educational needs. Additionally, it was noted that there was insufficient ongoing evaluation to ensure these standards are effectively implemented and maintained over time. Finally, a **variation across different universities** in the process and quality of meeting accreditation standards was suggested.

> "Despite the standards, and this was more around the Indigenous content, was that it's possible to get accreditation to tick all of those boxes and then still not have any kind of substantial content or have actually substandard content." (Academic 1)
>
> "You have to satisfy, you have to show how you satisfy all of these standards in your accreditation document that you give to ANMAC, but there's never any follow-up. There's never any, how was this achieved? What do students think? It's not, it's not analysed, you know, as well as those critical things, you know." (Academic 1)
>
> "It can be different for each university too. So, yeah, so, and the thing is too often, I think when they're doing accreditation, they're never, they're never written from scratch." (Academic 1)

Academic 1 expressed concern that there might be potential bias in the accreditation process, as students selected for interviews by accrediting bodies like ANMAC are often chosen by staff, which may skew the feedback received. Additionally, concerns were raised about the diversity and critical assessment capabilities of accreditation review panels, such as those assembled by ANMAC, which evaluate accreditation documents.

> "So, you know, ANMAC put like a panel together to go through it. You know, how diverse are those panels? Are the panels looking at this, at this content really critically, or is it just kind of, I often think it's, I often think it's a little bit of a tick box exercise sometimes." (Academic 1)

iii. Recognising the existence of R&D and/or B&H

Regarding the existence of R&D and/or B&H in the academic setting, Academic 2 highlighted that instances of discrimination may not be frequently reported or raised **within the institution**. However, they questioned whether this absence of reporting was due to a small number of incidents or discomfort in reporting such issues. Academic 2 perceived their **workplace to be generally collegial and supportive**, which might be the reason for the small number of reported incidents. They reported that, while the frameworks were typically effective, there were **occasional incidents** where the structures were in place for behaviours to be escalated for further intervention.

> "In terms of within the school, within staff in the school, I haven't had any, it hasn't been raised with me as I was saying, but that doesn't, I'm not trying to say that it doesn't happen, it's just not been raised, so yeah, it's a hard one to answer." (Academic 2)
>
> "But I guess generally speaking the frameworks are in place in this school. Occasionally the wheels might fall off, let's say, and some behaviours would need to be escalated, but if that happens it would be fairly rare, I think, from my experience working here and from what I've observed. So, I think generally it's a fairly safe work environment from a cultural perspective, but obviously I'm white, so I might be a bit colourblind in that respect." (Academic 2)

In relation to **preventing and addressing conflicts during clinical placements, the importance of** explicitly **encouraging students to report issues** they encounter during clinical placements and creating a supportive environment where students feel comfortable seeking help was mentioned.

Academic 1 stressed that students were **not in the workplace to be abused or harassed**. In addition, they provided students with a briefing before they go out on clinical placements reinforcing policies regarding bullying and harassment. These policies were reinforced during clinical placements (Academic 1).

> "So, I make a real point of them understanding that they're not in the workplace to be abused, to be harassed, and that they really should get in touch with us, you know, that my duty of care doesn't stop at the hospital at all, that, you know, they're still my students." (Academic 1)
>
> "I've had students get in touch with me when they've had issues, because I've given them permission to reach out. So maybe that's something that I can bring up and we can, you know, do a little bit more of. But just around that pastoral care of them, I think." (Academic 1)

Academic 1 also observed the frequent occurrence of **sexual harassment** in the nursing profession, highlighting it as a common issue that particularly affects young and potentially vulnerable students.

They also highlighted the importance of including content addressing **sexual harassment** and abuse before students' clinical experience.

> "Because it happens, it happens all the time [sexual harassment]. And especially, you know, my young gorgeous students are out there, you know, and some of them are a bit vulnerable sometimes." (Academic 1)
>
> "And so, you know, because we're talking about sexual health of patients, you know, with various chronic conditions. But then I realised that I had another slide that I had to put in around sexual harassment and abuse of nurses and things like that." (Academic 1)

Academic 1 observed that the **absence of reported racism** in clinical practice could be because students may experience racism but not report it. They also recognised the tendency of students to dismiss or minimise experiences of racism, either because they perceived it as a common, insignificant occurrence or because they felt powerless to address it.

> "I've not really had any issues around students that are reporting racism on clinical practice or anything like that. But that doesn't mean they don't experience it. I think a lot of students might experience things that they just either are used to, you know, that are, you know, racism is an everyday occurrence in Australia." (Academic 1)
>
> "So, they just kind of brush it off or they don't think it's a big thing or they feel powerless to raise it, if that makes sense." (Academic 1)

Academic 2 highlighted that students' behaviours in clinical settings are also evaluated, ensuring that they adhere to expectations of respectful and professional conduct. This evaluation is part of the broader educational assessment, setting clear repercussions for unprofessional behaviours.

> "When students go to clinical settings, these behaviours are evaluated. Yes, definitely. It is part of the student charter. They're required to behave, speak and act respectfully, and I certainly have meetings with students who've been on clinical placement who haven't behaved that way, and they have certainly failed units of study based on that." (Academic 2)
>
> "Okay, so there are repercussions if they don't behave professionally, and we do have a professionalism committee that occasionally a student will be referred to as the next step up beyond the chat with them and failing the unit if the behaviour continues, or if it's severe enough, they're referred to that professionalism committee." (Academic 2)

c) Australian culture

For this theme, two subthemes were identified (Table 6.3):

i. Diversity of the Australian society; and

ii. Prevalence of R&D and/or B&H in society (not in hospitals).

i. Diversity of the Australian society

Academic 1 placed personal value on cultural diversity. They appreciated the rich cultural tapestry of Australia and the natural inclination towards cultural clustering, where people seek community with people from similar cultures. It was observed that the presence of distinct CALD communities in some areas of the city provides comfort and a sense of belonging to individuals and **coexistence** may increase tolerance.

> "In [suburbs of the city] there's Samoan churches, there's Filipino churches, there's, you know what I mean? So, yeah, yeah, and there is that comfort in culture and people with a shared understanding." (Academic 1)
>
> "… the diversity of foods and cultures and things like that and yet there's no real racial unrest." (Academic 1)

ii. Prevalence of R&D and/or B&H in society (not in hospitals)

The **prevalence of R&D and/or B&H in Australian society** was commented on by Academic 1. It was acknowledged that there was the possibility of normalised, everyday racism in Australia that students might be accustomed to, hence not bringing it to the attention of the academic staff. They also recognised the impact of the COVID pandemic and political climate on racism. They suggested that such events could contribute to an environment where racism becomes more pronounced or acceptable.

> "But that doesn't mean they don't experience it. I think a lot of students might experience things that they just either are used to, you know, that are, you know, racism is an everyday occurrence in Australia." (Academic 1)

6.3.4 Experiences of the elements of IPCC in one school of nursing in relation to educational preparation and clinical practice: Clinical educators' views

The analysis of the clinical educators' (CEs') interviews identified three main themes (Table 6.4):

a. The paradox of R&D and/or B&H;
b. Educational preparation and management of the clinical experience; and
c. Australian culture.

Table 6.4. Clinical educators' experiences: themes and subthemes

a) **The paradox of racism and discrimination and/or bullying and harassment**	i. Personal and vicarious experiences of racism and discrimination and/or bullying and harassment	
	ii. Read about, but not seen, racism and discrimination and/or bullying and harassment	
	iii. Forms of preventing and/or addressing racism and discrimination and/or bullying and harassment	
b) **Educational preparation and management of the clinical experience**	i. University students' characteristics	
	ii. Enhancing clinical preparedness through comprehensive BN curriculum integration	
	iii. Cultivating the elements of IPCC and professional development through building supportive and inclusive clinical environments	- Fostering a protective, supportive and inclusive environment - Shaping the future nurse
c) **Australian culture**	i. Prevalence of racism and discrimination in society (not in hospitals)	

a) The paradox of R&D and/or B&H

The theme "The paradox of R&D and/or B&H" refers to the contextual characteristics and dynamics present within clinical environments in Australia. This theme comprises three subthemes (Table 6.4):

i. Personal and vicarious experiences of racism and discrimination (R&D) and/or bullying and harassment (B&H);
ii. Read about, but not seen, R&D and/or B&H; and
iii. Forms of preventing and/or addressing R&D and/or B&H.

i. Personal and vicarious experiences of R&D and/or B&H

This subtheme refers to the identification of experiences of R&D and/or B&H, the various forms in which these behaviours may be manifested, and preventing and addressing these behaviours within the clinical setting. Although not all the experiences in this subtheme are directly related to students' educational experiences, they are intentionally described to provide context about what occurs in the clinical environment and to illustrate the **frequency and forms of these situations** within the healthcare team.

There was a paradox in the perceptions of the prevalence of R&D and/or B&H among CEs. To begin with, CE 1 acknowledged the **prevalence of bullying** in healthcare, indicating that bullying against nursing students is a common issue in Australia. However, other CEs said that the frequency of such incidents in nursing is low or rare, yet stated that they persist despite the existence of zero-tolerance policies (CEs 3 and 9). There were differences in the experience of bullying too. One CE revealed to have **personally experienced bullying and harassment** (CE 1). Conversely, three CEs declared they had not been bullied (CEs 3, 4 and 8).

> "I definitely think sadly that racism and discrimination is definitely the most common but bullying and harassment is just becoming something that is not uncommon." (CE 1)
>
> "It still happens. Although there's zero [tolerance], they call it, you know, zero tolerance to bullying, you know, it's all over the … the posters are all over the hospitals and all that, but it still happens." (CE 3)

Two of the nine CEs revealed **personal experiences** of R&D in the clinical setting (CEs 5 and 8).

> "So, a lot of people [judge you] base you on your physical aspect as well, like on your physical appearance, the way you conduct yourself, the way you speak." (CE 8)

Similarly, **vicarious experiences** of R&D and/or B&H in the clinical setting were reported by five out of the nine CEs (CEs 4, 5, 7, 8 and 9). These incidents varied in type and sources (nurses, patients, surgeons to students or other nurses). The challenges of confronting such behaviour were also acknowledged (CE 9). The **non-linear nature** of bullying was highlighted, noting that it can occur in multiple directions and involve anyone in the environment (CEs 4, 5, 6, 7 and 8). Examples of student harassment by both a patient and staff members were also identified (CE 9).

> "I was once working in an ICU, and there was a student from an African culture … after the handover, one of the team leaders said to the first RN, are you going to take the student, she goes, no, no one can take students, and by the time she got to the third person, I said, excuse me, can we just stop right there, I need to speak to the nurse educator … if I was an RN working in that ward, I would have personally said, oh, look, I'll take her, that's no problem, but nobody put their hand up." (CE 9)
>
> "So, bullying is not linear, just one. Like in terms, anyone can do that … Like whether it's just a facilitator bullying a student or a staff bullying the student, vice versa. It can be." (CE 8)

Another contradiction was found in CEs' perceptions about **students engaging** in R&D and/or B&H. It was disclosed that students could also engage in such conduct, for example, by using **discriminatory language or labelling patients** (CE 2), or threatening a clinical educator (CE 4). Moreover, CE 8 commented on a tendency for **local students to engage in bullying more frequently**, possibly due to feeling more empowered in their home country. Conversely, CE 7 observed an absence of student-to-student discrimination at this university.

> "I had a debrief with students before, where sometimes the language they use is discriminatory, but they use that language, or they label a patient, for instance, or these kinds of things that they're not super aware of … They shouldn't be labelling patients." (CE 2)

> "Local students tend to bully more. Because maybe they feel more empowered, maybe? Yeah, you came here to this country, your English is not good. Who are you?" (CE 8)

ii. Read about, but not seen, R&D and/or B&H

Contradictory information was identified in the responses provided by three of the CEs concerning **personal or vicarious experiences** of R&D and/or B&H. For instance, initially, CEs 2 and 6 stated that, while certain about having experienced or witnessed situations related to R&D and/or B&H, a specific example could not be recalled. However, later CE 2 provided many examples of forms of R&D and/or B&H. Similarly, CE 3 initially acknowledged that bullying did occur despite the zero-tolerance policy. However, they later noted that, in their professional experience, such situations were uncommon. Finally, CE 7 initially stated that bullying and discrimination was highly prevalent in the nursing profession and emphasised that they have encountered these issues throughout their career. Later CE 7 clarified that, while they have *heard* about situations involving R&D and/or B&H, they have never personally witnessed such incidents.

> "I'm sure I have [witnessed and or experienced situations linked to R&D and/or B&H]. But if you ask me when. No, I can't think of a specific situation, but I'm sure, I'm sure I have witnessed or at least, you know, I've seen it." (CE 2)
>
> "No, I haven't encountered that [discrimination against students based on ethnicity]. Perhaps the hospitals where I teach, obviously their staff would be very well educated in bullying. It's obviously something. But look, it does occur, you know, but I haven't really encountered anything." (CE 6)

iii. Forms of preventing and/or addressing R&D and/or B&H

It was agreed by some CEs (CE 2, 5 and 8) that R&D and/or B&H could be expressed in multiple forms in the clinical setting. For instance, they can be expressed by group alignment, where nurses are **subtly or deliberately excluded** from social interactions (CEs 2 and 5); are **assigned difficult or unfavourable work conditions** (CE 8); are exposed to **coercive decision-making**; are the subject of **microaggressions** and passive-aggressive behaviour (CE 2); or are **intimidated** by colleagues (CE 5). R&D and/or B&H could comprise **subtle actions and remarks difficult to prove**,

such as making faces or making comments about language comprehension, or displaying discriminatory behaviours based on **appearance, age or ethnicity**, but not overtly expressed (CEs 2, 5 and 8). Other forms of discrimination are where **men in nursing face differential treatment**.

> "It comes in so many forms. I think, I think the aggression, for instance, sometimes it's as I've said microaggression, passive aggressive comments or pressure and decision-making would be, for instance, you know, like someone wants to swap [a shift] with you." (CE 2)

Another form of R&D was linked to the formation of **cultural cliques**, often driven by the language spoken (CEs 2 and 5), hierarchical tensions and resentment (CE 5), or influenced by **political and historical contexts** (CE 2). In the situation described here the discrimination was reversed:

> "You know, like in my practice I see lots of comments about different cultures, how they only want to work together as a clique and they only want to work together in their culture and then when a white Australian comes into that culture there's a lot of, they won't help the white Australian … their comments were we don't help casuals or agency staff because they get paid more than us so we let them, they have to do everything on their own." (CE 5)

Discrimination towards students could manifest in the form of exclusion from social spaces such as the tearoom (CEs 9 and 2), **student marginalisation**, or disrespectful professional interactions (CE 2).

B&H against students can manifest through **intimidating** behaviour from RNs or inadequate workload and responsibilities (CE 9).

> "But a number of times I've had to step in, and I've also had students that weren't allowed in the tearoom because the staff wanted to talk about the students." (CE 9)

It was observed that CALD students may face additional challenges in the clinical setting. For instance, R&D can be manifested as an **unequal treatment** based on students' accent, gender identity, sexuality or religious beliefs (CE 2). Additionally, there was sometimes the preference of

RNs and staff to **work with local students instead of engaging with students who were not fluent in English** or who had noticeable accents (CEs 2 and 8).

> "So even the staff, they said they would like to be buddied with a more local student than an international student, because I think it's just the way it makes it easier for them as well. To delegate tasks or to give instructions, especially in terms of language." (CE 8)

CEs identified several strategies designed to prevent R&D and/or B&H, citing the importance of **enforcing a zero-tolerance policy** with visible information in hospitals (CEs 2, 3, 4 and 6) and **understanding the students' perspectives** on diversity and inclusivity (CE 1). Additionally, the importance of being **prepared and confident** when discussing these topics, and avoiding assuming that students have a uniform understanding of these issues, were also mentioned (CE 1). **Respecting others** in the healthcare setting was highlighted by five CEs as a key factor in preventing R&D and/or B&H (CEs 4, 5, 6, 7 and 8).

> "I feel like sometimes we have to define those unpleasant experiences to students in some situations. Some of them have a good understanding, others don't. So not to assume that everyone knows the textbook definition of bullying and harassment and because to be able to identify something you have to really know a lot about it." (CE 1)
>
> "So, we make sure that we ask that particular individual how they wish to be identified. I think there's so much literature now on cultural diversity and, for example, transgender and non-binary, everyone wanting to be recognised, but they're still an individual and they still have emotions and feelings, and they still need to be respected. So, I don't have an issue with that myself. I'm very happy to respect it." (CE 6)

CEs described **building strong professional relationships and promoting teamwork and collaboration** with nurses and staff on the ward as being helpful in preventing R&D and B&H (CEs 1 and 5). **Effective communication** was highly valued in maintaining a positive learning environment (CEs 3, 4, 6 and 8). For example, they stressed the importance of clearly communicating students' objectives and the purpose of their clinical placement to the staff (CE 3), as well as engaging with RNs and staff, particularly when handling sensitive situations (CEs 4, 6 and 8).

> "We try as well to speak to the staff, about students' objectives, the reason why they're there, and the objectives of this practice, of this clinical placement. And if they listen well enough, really good, but if they don't, at least we've tried our best to, because it's at the end of the day, we're not there permanently." (CE 3)

Another strategy used to address R&D and/or B&H was **being aware** of the various forms in which R&D and/or B&H can manifest, **teaching students how to recognise them** (CEs 1, 6, 7 and 8) and educating them on how to escalate concerns when they feel intimidated or exploited (CEs 2, 3, 4, 5, 6 and 7). **Reflection and debriefing were also seen as key strategies to address** R&D and/or B&H, because group debriefs provide a platform to critically analyse different situations, fostering awareness and support among all group members (CEs 1, 2 and 9).

> "However, we encourage them to talk about it. It's not a taboo concept … So, not to sweep it under the carpet, not hide it. Always make sure that you raise it. Always make sure that you talk about it." (CE 1)
>
> "So, yeah, talking about what it looks like [R&D and/or B&H]. And then, yeah, hopefully making them feel comfortable enough to come and report any [situation]." (CE 7)

Addressing the need for students to prevent R&D and/or B&H when they become RNs requires the students to actively **engage and participate in the workplace**. Students are encouraged to develop friendships and rapport with everyone on the ward, fostering a positive and supportive work environment where they may feel comfortable speaking up should they encounter uncomfortable situations (CEs 7 and 8). The importance of reinforcing **students' future responsibilities** to avoid engaging in bullying was also highlighted, while emphasising the need for a support system where individuals can openly discuss these situations (CEs 2 and 7).

> "I would say, try and develop relationships. So, when you become a new graduate nurse, get to know your ward clerk, get to know the cleaners, the ward assistants. Make, develop friendships and rapport with everyone on that ward because that's going to be your workplace. Yeah, it's a team at the end of the day." (CE 7)
>
> "But also, I remind them that when they become the registered nurses, when they qualify and they become the nurse themselves, make sure they don't participate in the bullying, in the cycle of bullying." (CE 2)

The **workplace culture** and environment influence the prevalence of R&D and/or B&H (CE 4). In some organisations, staff exhibited indifference or apathy towards the student experience, with varying levels of willingness to engage with them, often influenced by factors such as overwork or personal issues (CEs 3 and 8). The **crucial roles and responsibilities of managers** in addressing R&D and/or B&H in the workplace were also recognised (CE 1 and 5).

> "Well, I would say I think different hospitals, they have sometimes – you can feel that – they call it the working culture. Staff have different working cultures. Some staff are very accommodating. When you go to one place, you know, everyone's lovely. They're very approachable, very accommodating, they're very inclusive … But when you go to another place, they kind of, you know, like, I would just think, you know, they're overworked, so they don't have much time to, you know, to probably, you know, explain things with students and all that. So, it's kind of, you can feel the difference." (CE 3)

Another strategy employed by CEs to address and prevent R&D and/or B&H was the **management of conflict**. Some of the approaches used to **deal with conflicts** were discussing the nature of the issue (CE 8) and the context of incidents (CE 1), and speaking directly to those involved in them (CEs 3, 4 and 8).

> "So, I always give it the benefit of the doubt. You cannot just make assumptions based on one person's feedback, like whether a student or a staff. So normally I take it with a grain of salt. I don't judge because of he said, or she said, no, no. I have, you know, I have to gauge. And if it's something really like ongoing, I say, okay, let's give it a day, maybe tomorrow. You have to start and communicate with the staff in case you get buddied and see how you go." (CE 8)

b) Educational preparation and management of the clinical experience

This theme identified aspects and situations that help to build or strengthen the elements of IPCC in students in the clinical setting. The subthemes identified for this theme were (Table 6.4):

i. University students' characteristics;
ii. Enhancing clinical preparedness through comprehensive BN curriculum integration; and

iii. Cultivating the elements of IPCC and professional development through building supportive and inclusive clinical environments.

i. University students' characteristics

CEs acknowledged the **significant diversity** among university students. This diversity was due to the presence of students from different age groups (CEs 3, 8 and 9), varying academic levels (CEs 3 and 9), LGBTQI+ students (CE 4), and Caucasian local students and those with CALD backgrounds (including both international and local students) (CEs 1, 2, 6 and 8). This diversity could potentially influence students' experiences and learning outcomes (CE 1).

> "Well, actually, we have different calibres of students, I have to say, because you do have the international students, you have culturally and linguistically diverse students, you have LGBT students, and you have your Australian-born students." (CE 1)

Regarding **CALD students** (both local and international), the importance of knowing them better to understand their needs, integrate them and facilitate their assimilation was emphasised (CEs 6 and 8). International students may face **additional challenges**, such as integrating into the clinical environment or adjusting to university and work life, frequently feeling unwelcome, and lacking the level of support they would typically receive in their home country (CE 8). Additionally, it was observed that **international students** often face significant challenges related to **language and communication skills** (CEs 2, 6, 8 and 9). These difficulties can affect their ability to express themselves, interpret interactions and follow instructions correctly. However, sometimes communication challenges may be more closely related to **students' self-confidence** in handling language fluency (CE 2).

> "A lot of the students just really struggle with the basic English language skills. So, I'm here to teach nursing, not to teach English, which is really, really hard as well … So, they have to do some English, but sometimes it's not even enough, really not enough." (CE 8)

CE 6 identified additional **cultural challenges** faced by male international students from male-dominated cultures. In their experience, these students often struggled to adapt to a female-dominated profession and, at times, adopted a "know-it-all" attitude as a coping mechanism.

> "And I'm thinking now of, it's happened quite a few times with male students, some from [male-dominated cultures named]. The question is, of course I'm generalising, but coming from those different cultural backgrounds into a female-dominated profession, there has been a little bit that I've noticed as well as saving face and pretending that they might know things that they don't." (CE 6)

Differences between local Caucasian and CALD students were identified. CE 8 believed that local **Caucasian** students tended to exhibit greater confidence compared to their CALD counterparts, noting the **impact of culture on self-confidence**. Another difference they identified was the willingness to **recognise or speak out about uncomfortable situations**. Some students from CALD backgrounds often used a strategy of "staying under the radar", avoiding drawing attention to themselves and steering clear of conflicts (CE 5).

> "Some students from different cultures, I don't know whether I can define the culture, they don't want to make any sort of like problems or issues what they deem as problems or issues, yeah, they just go under the radar." (CE 5)

ii. Enhancing clinical preparedness through comprehensive BN curriculum integration

The CEs identified elements within the BN curriculum that they believed helped to improve the educational preparation of students for their clinical experiences.

They believed that the content organisation played a positive role in fostering the elements of IPCC. **Regarding legal and ethical content**, seven of the nine CEs emphasised the importance of students having a clear **understanding of regulatory documents and their scope of practice** (CEs 1, 2, 3, 4, 6, 8 and 9). Additionally, the students' assessments were oriented to assess these specific areas during clinical placements (CEs 1 and 6).

> "Sometimes if they talk about patients, I do make sure I remind them that they are assessed against the NMBA standards as well, where they have to demonstrate competence in understanding cultural diversity and in actually making sure that they are providing care to all patients equally, without any bias because of sexual identity, age, gender, any kind of difference." (CE 1)

The elements of IPCC were nurtured in simulation activities that reflect the societal **diversity in clinical scenarios** (CE 2) and in clinical placements. It was felt that **clinical placements were recognised as valuable learning opportunities**, allowing students to interact with multicultural communities (CEs 2, 3, 4 and 7).

> "Because it's a multicultural country, which is amazing, there's so much to learn from, you know, people who have come from other cultures, different ways of thinking, different ways of being. So, yeah, I always try and teach students to celebrate that and to be so open to other ways of thinking." (CE 7)

The clear understanding that exists among students about the boundaries and expectations surrounding social media use and professional behaviour was identified (CEs 1, 5 and 6). Having a formal policy governing it within the university was seen as valuable (CEs 8 and 9), as was discussing the appropriate use of social media in the orientation and debriefings (CE 1, 2 and 3). However, CE 2 described some inappropriate use of the internal anonymous system employed by the university for student feedback. This system sometimes enables individuals to hide behind screens and make harmful comments without facing consequences.

> "I personally know that when I mention it [the social media use policy] to the students, I feel like everyone knows that this is a red line." (CE 1)
>
> "The surveys are to click the link and write the overview. So, they [students] go there, they write, and then the system generates it for the academic. '[name] is amazing. [name] is very kind to students.' And these are the things. Okay, all right, that's fine. But sometimes, not particularly for me, but I've seen names of my colleagues, and they were like paragraphs of bad things. So yeah, from a professionalism perspective. Just to clarify, you get the entire piece of comments, even though they are not for you or from you, from your students. So, you can say, 'oh, I don't know, [name] has got this very bad comment. And I don't know, [name]' " (CE 2)

iii. Cultivating the elements of IPCC and professional development through building supportive and inclusive clinical environments

This subtheme refers to the everyday actions that CEs undertake in the clinical setting to strengthen the elements of IPCC in students. It was divided into two aspects, which were:

- Fostering a protective, supportive and inclusive environment; and
- Shaping the future nurse.

Fostering a protective, supportive and inclusive environment

Other strategies used by CEs to cultivate the elements of IPCC and professional development were **fostering a protective, supportive and inclusive environment**. The **creation of an open, respectful, inclusive and culturally safe environment** for students, patients, RNs and staff was highlighted by six CEs (CEs 1, 2, 3, 4, 6 and 7). The need for **proactive and supportive supervision** (CEs 4 and 9), **regularly monitoring students' wellbeing and mental health**, and focusing on identifying symptoms of anxiety, burnout and fatigue in both students and colleagues (CEs 4, 6 and 8) were also mentioned.

> "We'll create a positive environment for them, because otherwise they will be just answering the buzzer … and then I'll go through them, make sure they take a photo of the objectives." (CE 4)
>
> "And also acts of kindness can be just so important. But also, for those people on the other side who are experiencing burnout or compassion fatigue, we really need to be addressing those particular issues and seeking help." (CE 6)

Both the importance of **being physically and emotionally present** to support students in challenging situations (CEs 1, 3, 4, 5, 6, 7 and 9), and the **value of active listening**, demonstrating engagement and empathy towards students, were identified (CE 1).

> "Really being there sometimes to support them is one thing, but also being an active listener, in my opinion, is very important to help them feel that it's a safe space, showing them that you're engaging, but you're there for them, but at the same time, allowing them to talk and unpack, being gentle, always reassure them, always talk about." (CE 1)

To foster the elements of IPCC and support professional development, CEs described taking several actions aimed at protecting and supporting students. For example, they advocated for students by finding **appropriate placements** when RNs make them feel unwelcome due to workload pressures (CEs 3, 8 and 9). They also ensured that students are paired with **supportive mentors**, safeguarding them from intimidation or humiliation (CEs 3, 8 and 9). Additionally, CEs clarified the **students' roles** to qualified nurses, emphasising that students are there to learn and gain experience rather than taking on the full range of nursing tasks (CEs 3, 5 and 9). They also set **clear expectations** for clinical placements by encouraging students to communicate their skills and capabilities to RNs (CEs 4 and 8).

> "It's not fair for the students to be, you know, they're there to learn. That's, that's fine for my data. They're there to learn and they're there to maximise basically the opportunity. But if someone's trying to intimidate them or humiliate them, it's not fair for them. So, we need, we need to, yeah, resolve this immediately." (CE 3)

Shaping the future nurse

Finally, to foster the elements of IPCC and support professional development, CEs focused on their personal strategies used to help students to **shape their professional identities as future nurses**. **Mentoring, role modelling and leading by example** were highlighted by CEs as key strategies (CEs 1, 2, 6 and 7). **Sharing personal experiences to build trust and shape professional identity** were also emphasised (CEs 1, 4 and 7). Demonstrating **professionalism in interactions** with other nurses during clinical placements (CE 2), treating them with respect (CE 4), building rapport and good relationships (CEs 3 and 7), and **working collaboratively** with RNs, staff and patients to support the students during their clinical placements (CEs 3 and 7) were also important, as students tend to observe and emulate the behaviours and interactions of their mentors (CEs 1, 2, 6 and 7).

> "As a clinical facilitator, first and foremost, I personally think that there's a lot of mentoring to our students … so, we need to set an example in the practices of the briefing and the meet and greet sessions that I conduct with my students." (CE 1)
>
> "And I really like giving personal examples and telling personal stories of I guess moments in my nursing where patients may have come across as defensive or rude or they're swearing at me or whatever the case may be." (CE 7)

CE 2 recognised the importance of understanding students' diverse backgrounds and noted that some may not be aware of their inappropriate behaviour. In these situations, CE 2 believed the role of the CE was to raise awareness of professional conduct, helping students learn about professionalism and the expected behaviour in the workplace.

> "So, that's another thing I think, because obviously everyone's raised differently, sometimes students aren't even aware that the terms that they're using are not appropriate, because it's probably tolerated at home, it's probably tolerated in their school, it's probably tolerated in their group of friends, suddenly they go out in a professional capacity, and they're like, oh, I didn't know that I had to behave a certain way, a certain level of respect, and professionalism is expected for me, so that's raising awareness and letting them know, and you can't do that without an example." (CE 2).

The key role that **debriefing** played in shaping the professional identity of future nurses, particularly in terms of the elements of IPCC, was also acknowledged. Debriefing sessions were used to report incidents, unpack patient behaviours, reinforce communication, and remind students about the availability of support from CEs (CEs 1, 5 and 6). Additionally, debriefing provides an opportunity to give constructive feedback when needed and encourages students to reflect on their experiences (CE 2) or to address instances of discrimination (CE 7). The facilitator was felt to play a crucial role in **guiding and stimulating discussions** during debriefing sessions, correcting misconceptions, encouraging critical thinking and debating different perspectives on situations (CE 2).

> "I think it should be pointed out in a professional manner, debriefing, let the student know the behaviour you showed was not right, and then ask the student to reflect on why, and then they get an insight of why it's wrong or why it's not right, and that's a way to make the student realise as well, don't just tell them." (CE 2)

To foster the elements of IPCC and support professional development CEs **reinforced culturally sensitive practices**. These could be achieved by valuing **culturally sensitive communication** (CE 1) and **cultural differences and cultural competence** (CEs 4 and 5), **demonstrating awareness about** patients' cultural backgrounds during care delivery (CE 3), or **respecting patient preferences** about who provides their care (CE 4 and 6).

> "Perhaps, you know, you might see that in more male and female. You know, like an older adult who is female may not want to be cared for by a male nurse when they're being watched or attending activities of daily living. Patients' cultural and religious sensitivities or maybe Muslim patients. I hear that too. So, you have to be really respectful of both sides." (CE 6)

Additionally, CEs provided students with **tools and strategies** to use in their future professional roles. To begin with, educating students about the importance of navigating different people's **behaviours and personalities** (CE 3) and providing students with **diverse perspectives** to interpret situations (CEs 4, 7 and 9) were highlighted.

> "There are people that don't turn up and when that happens, people get a bigger workload than they're even supposed to. You know, they're stressed, things are going wrong, we don't know what's happening at their home life and things like that. But still, you know, as a professional, you have to be aware of those things and you come to work, you know, work is a different place." (CE 9)

c) Australian culture: Prevalence of R&D in society (not in hospitals)

Two CEs (7 and 8) discussed the **prevalence of R&D in Australian society**. They mentioned that, despite existing laws and regulations, discrimination remains embedded in Australian culture, highlighting that societal norms often perpetuate discriminatory behaviour. CE 7 identified the tendency for people, particularly those born in the country, to be dismissive towards others who have language barriers or limited functioning.

> "Related to racism, let's go. Look, I know that it exists, I know that particularly if there's a language barrier or staff members, English is quite limited. It can be easy for particularly people born in this country to be a little bit dismissive or think that there's, you know, it's probably the same in disability, anyone with limited functioning." (CE 7)

CE 8 observed how **age and physical appearance can be sources of discrimination**. CE 8 also identified preferential treatment in terms of allocation of job opportunities, and promotions based on the university a student is from.

6.4 Discussion

This study aimed to explore the views of educational and regulatory experts in relation to the elements of IPCC in Australia, and also to explore the experiences of the elements of IPCC in one school of nursing in relation to educational preparation and clinical practice.

6.4.1 Educational preparation

Accreditation framework in Australia

The accreditation of educational providers and nursing programs in Australia is conducted by the Australian Nursing and Midwifery Accreditation Council (ANMAC, 2019). Each university or educational provider is responsible for interpreting these standards and incorporating them into the curriculum, taking into account contextual factors.

Regarding the accreditation process, the three experts opined that, despite the clarity of written accreditation standards, a gap may sometimes exist in the translation of these guidelines into practical actions within certain educational and professional settings. One expert proposed emphasising practical strategies and actions to ensure these standards are actively applied and effectively implemented by all educational providers. Experts and academics acknowledged that accreditation standards set a baseline for educational quality and professional practice and appreciated the improvements implemented over time. However, these two groups also noted variability in how content associated with the elements of IPCC is taught across institutions.

Experts and academics offered a somewhat critical perspective on the accreditation process. They observed that institutions might achieve accreditation by superficially meeting these standards, without showing substantial engagement. Additionally, they highlighted a lack of rigorous monitoring to ensure these standards are thoroughly implemented and maintained over time. Moreover, it was acknowledged that auditing educational standards and ensuring compliance are both laborious and expensive processes, with concerns that punitive measures may not necessarily improve how educational institutions maintain these standards. Academics and experts held differing views on student participation in the accreditation process. Experts

emphasised the importance of incorporating student feedback to understand how the curriculum is experienced firsthand. In contrast, academics raised concerns about potential bias, noting that students chosen for interviews may be selectively picked by staff, potentially skewing the feedback received. Academics also questioned the diversity of panels responsible for accreditation.

Experts acknowledged that regulatory updates have played a key role in shaping the nursing profession over time and addressing current issues. They reflected on the historical evolution of the NMBA Code of Conduct over the years, noting that while substantial progress has been achieved, there remains considerable work to reach the desired goals in relation to the elements of IPCC. Experts observed that regulations have served, and could continue to serve, as a powerful tool for delivering consistent messages across the broad network of practitioners. This strategy could be particularly valuable for promoting the elements of IPCC within nursing education and accreditation. One expert suggested that a similar approach to the integration of First Nations health content could be used to incorporate the elements of IPCC into nursing curricula and accreditation standards.

Both academics and experts expressed their views about the inclusion of First Nations health content in nursing programs. Experts noted the increasing acceptance of First Nations' perspectives, especially following the addition of a statement in the Code of Conduct. One expert opined that while complete integration has yet to be reached, they recognised a significant shift in perception, with the inclusion of the statement now seen as essential and widely endorsed. However, Academic 1, who identified as an Aboriginal person, expressed the belief that it is possible for institutions to achieve accreditation without including any meaningful or substantial content related to Aboriginal health.

Embedding IPCC across the curriculum

The combination of lectures, case-based learning and simulation activities has a positive impact on increasing students' cultural competence (Qin & Chaimongkol, 2021). Experts, academics and CEs concurred on the importance of consistently embedding content about the elements of IPCC,

diversity and inclusivity within the curriculum. Academics and CEs said the elements of IPCC were nurtured by reinforcing this content within the **units of study, simulation activities and clinical placements**. The information about regulatory documents and their scope of practice was highly valued by CEs, since it helps students to have a clear understanding of their obligations once they start their clinical placements. Clinical placements offer students valuable opportunities to experience and engage with cultural diversity and enable interaction with multicultural communities. This exposure may enhance their understanding of diverse cultures and positively impacts their experiences and interactions with a wide range of patients from different backgrounds (Akca & Ayaz-Alkaya, 2023; Hart et al., 2015; Power et al., 2020).

6.4.2 Clinical practice

Prevalence and Forms of R&D/B&H

The academics and experts in this study recognised R&D and/or B&H as pervasive challenges within the nursing profession, highlighting that these issues extend beyond cultural differences, beyond the nursing profession, beyond the health system and beyond Australia. Comprehensive definitions of racism, discrimination, bullying and harassment were presented in Chapter One. These perspectives align with research findings that show a high global prevalence of R&D (Cubelo, 2023; Gauci et al., 2023; Iheduru-Anderson, 2020; Tuttas, 2015; Wijayaratnam et al., 2024) and of B&H (Goh et al., 2022; Jones, 2017; Karatuna et al., 2020; Shorey & Wong, 2021) in nursing, as well as a high prevalence within the field in Australia (Correa-Betancour, Marcus, et al., 2024; Chun Tie et al., 2018; Dywili et al., 2021; Hartin et al., 2018; Mapedzahama et al., 2018; Parke et al., 2023; Zanjani et al., 2021).

However, contradictions emerged in the CEs' responses regarding their perceptions and experiences of R&D and/or B&H. Their interviews revealed a paradox: while some educators acknowledged that R&D and/or B&H frequently occur in clinical settings, they stated they had no personal or vicarious experiences of these incidents. Nonetheless, they were able to provide numerous theoretical examples of such situations. Additionally, inconsistencies appeared in the responses of three CEs regarding their personal or vicarious experiences with R&D and/or B&H,

highlighting varied perceptions and experiences within the profession. These phenomena may be attributed to increased education and awareness around these topics, particularly within nursing. CEs may be aware about the prevalence of these issues through media coverage, discussions with colleagues or institutional reports, which could lead them to view these problems as widespread, even in the absence of direct experience. Social desirability bias may also be a contributing factor. This bias is defined as the tendency to provide responses that are perceived favourably by others (Bergen & Labonté, 2020). Admitting to being a victim or witness of R&D or B&H can be seen as socially expected, leading participants to respond in ways that align with perceived social norms. Additionally, responses may have been influenced by what CEs believed the researcher expected to find. Further research exploring the underlying reasons for these responses would be valuable for a deeper understanding of this phenomenon.

Another contradiction emerged in CEs' perceptions of students' involvement in R&D and/or B&H, with some noting a tendency for local students to engage in bullying more frequently. Research on nursing students in Australia indicates that all students are exposed to both physical and non-physical violence during clinical placements; however, the primary sources of these aggressions are typically patients, visitors, RNs and other staff on the ward (such as enrolled nurses and assistants in nursing), rather than fellow nursing students (Budden et al., 2017; Hopkins et al., 2014). Nevertheless, almost no cases of racism were reported in clinical placements at this university, which according to the academics interviewed, may not be due to its absence, but rather to a tendency among students to downplay or overlook instances of racism, either because they view it as routine or insignificant or because they feel unable to take action. Academics acknowledged a robust level of institutional support and a strategic commitment to anti-racism and culturally respectful practices, as evidenced by the presence of mechanisms within the school for reporting incidents of disrespect, bullying or harassment. This strategic approach may or may not differentiate this school of nursing from other institutions. To reinforce this idea, the experts interviewed noted that an increase in reports of R&D and/or B&H in clinical settings would not necessarily indicate a rise in these incidents, but could reflect greater awareness and understanding of these topics.

Forms and sources of workplace R&D/B&H

The experts, academics and CEs identified various forms that R&D and B&H can take within nursing, affecting both colleagues and students. Academics and CEs noted that R&D and/or B&H often involve subtle actions and remarks that are difficult to prove. They observed that workplace racism, in particular, is becoming more covert or subtle, making it less visible, especially to those not directly affected. Examples provided by the three groups included group alignment and exclusion from social interactions, microaggressions, passive-aggressive behaviour, and assignments involving difficult or unfavourable work conditions, among others. All these challenges are well documented (Correa-Betancour, Marcus, et al., 2024; Chun Tie et al., 2018; Ng Chok et al., 2018). Similarly, participants in the three groups identified that B&H towards students can take various forms, including intimidating behaviour from RNs or unfair treatment related to workload and responsibilities. ~~Discrimination against students may manifest as exclusion from social settings, assignment to less meaningful tasks, or lack of respect in professional interactions, often influenced by their cultural background.~~ These results are comparable to those documented in prior studies (Abu-Arab & Parry, 2015; Birks et al., 2018; Budden et al., 2017; Brewer et al., 2024; Lim et al., 2023; Lin et al., 2021; Luders et al., 2021; Ryan & McAllister, 2019).

Regarding the sources of such behaviours, experts and CEs acknowledged the non-linear nature of R&D and/or B&H, noting that it can occur in multiple directions. Despite the fact that bullying and harassment are concepts that particularly consider in their definition an extent of power imbalance, multiple studies worldwide have provided evidence of nursing students' incivility or even harassment towards academics and clinical educators (Cassum, 2018; Christensen et al., 2019). These behaviours are categorised as attacks that could be verbal or due to students' tasks (for example, assignment submission), personal attacks (in the form of spreading rumours), and harassment through email or telephone (White, 2013). There is also evidence of such behaviours displayed by nursing students in Australia (Christensen et al., 2020, 2021).

CEs observed that students generally have a clear understanding of inappropriate behaviours on social media in relation to practising R&D and/or B&H. This awareness was attributed to the

university's preparation of students and the presence of a clear social media policy. However, instances were also noted where students used anonymous feedback channels to make harmful comments without facing consequences. Although the persistence of the situations was not further clarified in terms of the frequency of its occurrence, they could be classified as a form of cyberbullying. Cyberbullying involves the use of digital technologies to intentionally harass, threaten or harm others (Yosep et al., 2023). This can include activities like spreading rumours about someone, or sending derogatory, mean or hurtful messages, aimed at embarrassing or intimidating someone (Musharraf & Anis-ul-Haque, 2018). Cyberbullying differs from traditional bullying because it can occur anytime and can reach a wider audience very quickly, often making it harder for victims to escape, which potentially makes it more harmful than traditional forms of bullying (Yubero et al., 2017). Some of the strategies that have been used to deal with cyberbullying have been focused on increasing students' awareness and resilience to reduce the negative effects of cyberbullying (Yosep et al., 2023). This approach could be particularly beneficial in the undergraduate BN program in this study, where students are recognised for their strong awareness of appropriate social media use.

Evolving workforce diversity

Experts, academics and CEs also acknowledged the significant diversity within the clinical setting. Experts and CEs highlighted that the nursing workforce comprises individuals across a broad age range and includes both Caucasian nurses and those from CALD backgrounds. The evolution of diversity within the nursing workforce was also noted, with a significant increase over the past 20 years, now beginning to reflect the broader community. This aligns with data from the Australian Government Department of Health and Aged Care, which shows that the percentage of locally qualified overseas-born nurses increased from 16% in 2016 to 21% in 2022 (Australian Government Department of Health and Aged Care, 2023). Additionally, the percentage of IQNs remained stable at 22% between 2016 and 2022, with locally qualified overseas-born nurses and IQNs together representing 43% of the nursing workforce born overseas in 2022 (Australian Government Department of Health and Aged Care, 2023). The percentage of men in nursing has

also risen from 7.7% in 1997 to 12.4% in 2022 (Australian College of Nursing, 2021; Australian Government Department of Health and Aged Care, 2023).

Experts and academics recognised the challenges that IQNs face in clinical settings, particularly the often-misunderstood cultural differences. These challenges, documented in previous research, include the need for psychological adaptation and acculturation, language and communication barriers, variations in nursing roles and scope of practice, as well as experiences of R&D and B&H, among others (Correa-Betancour, Marcus, et al., 2024; Chun Tie et al., 2018; Ng Chok et al., 2018). Academics highlighted accent discrimination directed at nurses for whom English is a second language, particularly from older patients. This observation aligns with previous findings indicating that accent discrimination from patients remains an issue within nursing practice (New South Wales Nurses and Midwives' Association, 2019 Philip et al., 2019).

Academics also raised the probability of subtle discrimination in the promotion processes affecting IQNs and non-Caucasian colleagues, noting insufficient mentoring and support from supervisors as potential systematic barriers to career advancement. This issue would be reflected in the lack of diversity within leadership roles, with most NUMs being Caucasian, despite the diversity among nursing staff. These findings align with earlier studies in Australia, which highlighted inadequate induction and support (Chun Tie et al., 2018; Ng Chok et al., 2018; Correa-Betancour, Marcus, et al., 2024) and barriers to career advancement (Correa-Betancour, Marcus, et al., 2024; Dywili et al., 2021) for IQNs and non-Caucasian nurses.

In addition to the challenges faced by IQNs in integrating into the clinical setting, academics and CEs noted the formation of cultural cliques, where nurses from similar cultural backgrounds tend to work together in specific wards or departments. While CEs viewed this tendency negatively, academics suggested that, although it may significantly impact workplace interactions and dynamics, it could also serve as a potential strategy for preventing R&D and/or B&H in nursing.

Student diversity, barriers and clinical-placement experiences

Academics and CEs acknowledged the considerable diversity within the student population, including variations in age, academic level and gender identities, with both local Caucasian

students and those from CALD backgrounds, encompassing both international and domestic students. They recognised that these groups contributed distinct cultural perspectives and experiences to the educational environment. Experts also noted a notable increase in the representation of various ethnic and cultural backgrounds in recent years. In relation to international students, over the past decade, Australia has witnessed a substantial rise in their enrolment across all sectors, securing its position as the second-largest recipient of international students among the Organisation for Economic Co-operation and Development (OECD) countries (OECD, 2024). The count reached 710,893 international students in 2023, marking a 34% increase between the periods comprising January–July 2022 and January–July 2023 (Australian Government Department of Education, 2023a). There has also been an increase in the enrolment of overseas nursing students (Australian Government Department of Education, 2023b). In 2021, 17,112 students graduated with a BN, and 22% of these graduates were international students (Australian Government Department of Education, 2023b).

CEs noted that international students often face additional obstacles, such as adaptation to a new environment without the level of support they might have in their home countries. Language and communication challenges are also prevalent, which may impact their ability to express themselves, accurately interpret interactions and follow instructions effectively. These findings are consistent with previous Australian studies about CALD nursing students that have identified communication challenges (Graham et al., 2024) and difficulties in understanding local colloquialisms (Abu-Arab & Parry, 2015; Graham et al., 2024; Lim et al., 2023; Randon et al., 2020).

Additionally, experts and CEs identified that students with a CALD background experienced R&D and/or B&H during clinical placement. There are some studies about nursing students in Australia corroborating this, but the focus is on all nursing students, not particularly those with a CALD background (Birks et al., 2017, 2018; Budden et al., 2017). Some of the instances of R&D and/or B&H during clinical placement were described as indirect and subtle (Birks et al., 2017; Budden et al., 2017; Graham et al., 2024). Other instances were direct, in the form of public humiliation or verbal abuse (Birks et al., 2017; Budden et al., 2017; Graham et al., 2024), being denied

valuable learning opportunities (Birks et al., 2017; Budden et al., 2017; Graham et al., 2024) or in the form of physical aggression (Birks et al., 2017; Hopkins et al., 2014). This complex process of social integration could negatively impact CALD students' mental health and self-esteem, consequently affecting their ability to integrate.

R&D and/or B&H have severe consequences for both those who experience them and those who witness them. Nursing students have reported a range of impacts, including feelings of anger or guilt, low self-esteem and confidence, panic and anxiety attacks, chest pain, disrupted sleep patterns, physical illness (Birks et al., 2018; Fernández-Gutiérrez & Mosteiro-Díaz, 2021), and even thoughts of self-harm or suicide (Birks et al., 2018). Additionally, some nursing students express a desire to leave the profession after encountering or observing B&H (Birks et al., 2018, 2024).

Experts and CEs highlighted the importance of gaining a deeper understanding of CALD students to address their needs, promote integration and assimilation. Experts particularly emphasised the need to assist CALD students to practise in a culturally safe manner and encourage their adaptation to the Australian context, while respecting and preserving their cultural identities. Additionally, it was noted that male international students from male-dominated cultures encounter unique cultural challenges. These students often struggle to adapt to the female-dominated profession and may, at times, displaying an arrogant attitude as a coping mechanism.

Differences between local Caucasian and CALD students were particularly noted by CEs. To begin with, cultural background was observed to influence an individual's confidence in their professional abilities, behaviour, communication style and interactions. Local students were generally seen as displaying greater confidence than their CALD peers. Additionally, CEs noted a tendency among CALD students to avoid recognising or speaking out about uncomfortable situations, which may be interpreted as a strategy to avoid drawing attention or to prevent conflicts. These observations align with existing literature, which highlights the challenges some CALD students face in adopting a more direct communication style (Abu-Arab & Parry, 2015), or having interpersonal interactions with patients and peers (Abu-Arab & Parry, 2015), as well as

differences in cultural norms and body language (Abu-Arab & Parry, 2015; Lin et al., 2021; Newton et al., 2018).

Experts observed that, although universities often have policies to promote cultural competence, the academic calendars and current curricular structures do not always accommodate the needs of students and staff observing important religious events. A potential strategy to enhance support for cultural diversity within universities could involve implementing flexible work arrangements for both academics and students.

The strong connection between work environment and prevalence of bullying (Choi & Park, 2019), job satisfaction (Brewer et al., 2020; Karatuna et al., 2020) and turnover intention (Blackstock et al., 2015; Crawford et al., 2019; Hartin et al., 2018; Kim et al., 2019) has been demonstrated among nurses. Experts and CEs acknowledged that workplace culture and environment play an important role in the prevalence of R&D and/or B&H, work satisfaction and retention. These factors may also contribute to the early departure of experienced nurses. Furthermore, CEs observed the impact on students' learning outcomes when staff either collaborate with or alternatively show indifference towards them. This aligns with findings from previous research, which associated staff attitudes with either positive or negative learning experiences during clinical placements (Alshahrani et al., 2018; Bril et al., 2022; Jack et al., 2018; Luders et al., 2021; Papathanasiou et al., 2014).

Professional identity: formation and erosion

Work culture is closely linked to the development of professional identity, as it involves connecting with a peer community and contributing to a shared mission. Experts, academics and CEs agreed that this creates a complex issue whereby, despite efforts to educate about R&D and/or B&H, new graduates often quickly adapt to the existing culture of the institutions where they work, sometimes adopting these behaviours. This is concerning because, without challenging the existing cultural norms of predominantly Caucasian institutions, the cultural competencies learned during education may not be sustained over time, perpetuating unacceptable practices.

Professional identity can be understood as the experience and behaviour associated with being a nurse (Fagermoen, 1997). It involves a blend of personal values, attitudes and beliefs, along with a comprehensive understanding of the nursing profession (Leong & Crossman, 2015). Nursing professional identity is a dynamic, ongoing process that begins forming even before entry into undergraduate nursing education. It is shaped and adjusted through practice and professional development, continually evolving from undergraduate studies, through workforce entry, and as professional experience accumulates (Rasmussen et al., 2018, 2021). This professional identity is influenced by three interconnected factors: the self, the role within professional practice, and the context in which the role is performed (Rasmussen et al., 2018). Context plays a crucial role in shaping the professional identity of undergraduate nursing students. On one hand, nursing regulations and scope of practice, and on the other, university and organisational policies, provide a structured framework within which students develop their practice. However, orientation, education, role-specific support and access to role models also significantly influence students' inculturation and professional identity formation. Observing the behaviours and interactions of other nurses can shape students' perception of the nursing role and contribute to the development of their professional identity (Rasmussen et al., 2018). The professional identity of students and new graduates may be directly impacted by observing and emulating workplace practices related to R&D and/or B&H. Interrupting this cycle would be key to prevent the perpetuation of such practices.

A well-supported transition phase should offer resources and guidance to help new nurses integrate into the workforce, bridging the gap between theoretical learning and practical application (Alshawush et al., 2022). Participants suggested that fostering the elements of IPCC in healthcare organisations can be achieved through several strategies: enhancing workplace culture to improve retention and job satisfaction, addressing B&H while promoting psychological safety, advancing cultural competence and reflective practice, and supporting the development of professional identity in nursing. Additionally, certain strategies employed by CEs during clinical placements are highly influential in shaping a positive professional identity. Key strategies include mentoring, role modelling, leading by example, fostering collaborative work, demonstrating professionalism in interactions with other nurses and staff, and treating colleagues with respect.

All these strategies can contribute to fostering a positive professional identity in nursing students. The importance of reinforcing students' future responsibility to avoid engaging in bullying was also highlighted, while emphasising the need for a support system where individuals can openly discuss these situations.

Organisational, educational and clinical strategies

Experts, academics and CEs provided strategies to prevent situations of R&D and/or B&H at different levels. From an organisational point of view, it was suggested that smaller organisational settings may foster greater tolerance and inclusivity, potentially reducing the prevalence and impact of issues more commonly seen in larger and possibly more diverse environments.

There is no clear evidence supporting the relationship between organisational size and the prevalence of bullying. One study found that a high quality of human resource management practices appears more important for establishing a well-developed ethical infrastructure against workplace bullying than financial resources or organisational size. But organisational size was significantly and positively associated with having policies and training systems, as larger organisations are more likely to provide training and implement policies on workplace bullying (Einarsen et al., 2019). However, another study found that workplace bullying was less frequent in enterprises with fewer than 10 employees (Lagabrielle et al., 2022).

The vital roles and responsibilities of managers in addressing incidents of R&D and/or B&H were acknowledged. These findings align with existing research, indicating that managers do not always take these accusations seriously, contributing to the ongoing issue of underreporting (Anusiewicz et al., 2020; Karatuna et al., 2020; Kim et al., 2019; Luca et al., 2024; Pressley et al., 2022). Establishing a psychologically safe environment where healthcare professionals feel secure in reporting is essential.

From an educational point of view, experts acknowledged that educators (academics and CEs) play a crucial role in guiding students, developing a deeper understanding of the complexities of healthcare practice. However, they have a critical view of the current composition of academic

teams at different universities in Australia in terms of their diversity. Although diversity exists, some experts felt it is often not sufficiently represented at higher levels. Having a multicultural academic staff has been seen as a strategy to improve recruitment, retention and graduation rates, and serves as a model of leadership for students, increases diversity in the nursing workforce and, therefore, reduces health inequalities (Murray & Noone, 2022; Relf, 2016). Achieving equity in health requires a diverse nursing workforce that reflects the characteristics of society; However, there seems to be a systemic barrier that underrepresented groups or nurses from minority backgrounds face to access and advance in their academic career.

The first step towards building a more diverse workforce is to expand diversity within nursing education, ensuring a broader range of backgrounds and perspectives among future professionals. Reinforcing this idea, the First Nations academic in this study considered that most of the senior academics at this university were still predominantly Caucasian, while the other academic felt that the inclusion of First Nations academics may be an effort to diversify the university and integrate different perspectives into the academic setting. A proactive approach to fostering a more inclusive and equitable academic environment is known to be beneficial. For instance, this can be achieved by implementing targeted and affirmative action measures to support the diversification of the academic staff (Bradford et al., 2022).

Academics and CEs described a number of strategies that they employed to influence the comfort of students and improve their approaches to discuss sensitive topics. They observed that the cultural backgrounds and personal experiences of academics, CEs and students could assist these strategies. Academics used a range of techniques aimed at addressing this situation and to raising awareness about how systemic biases influence both the healthcare system and broader society.

Regarding strategies to use in the clinical setting to prevent R&D and/or B&H, experts and CEs acknowledged the value that **reflective practice** had on the development of the elements of IPCC in nurses and students. CEs observed the key role that **debriefing has as part of the reflective practice**, particularly in preventing R&D and/or B&H and shaping the professional identity of future nurses. CEs acknowledged the crucial role they play in **guiding and stimulating discussions**, correcting misconceptions and encouraging critical thinking. Creating spaces to have

sensitive and relational conversations provides opportunities to critically reflect and collaborate to prevent and address situations like racism and bullying (Luca et al., 2024; Mayoum et al., 2022).

Other strategies implemented during clinical placements to prevent R&D and/or B&H were also mentioned. To begin with, experts and CEs agreed on the importance of teaching the students **how to recognise** the various forms that R&D and/or B&H could take and educating students on **how to verbalise** when they feel intimidated or exploited. **Academics and CEs agreed on the importance** of making students aware that they should report any issues they face, enforcing a zero-tolerance policy before and during clinical placements and creating an open, before and during clinical placements where students feel comfortable seeking help.

CEs mentioned **fostering protective and supportive supervision** as another strategy to prevent R&D and/or B&H. This involves, for instance, securing appropriate placements and pairing students with mentors who understand their roles and challenges. Additionally, being physically and emotionally present and regularly monitoring students' wellbeing and mental health. Finally, CEs endorsed **strengthening teamwork and collaboration,** reinforcing culturally sensitive practices, and **assuring effective and direct communication** to maintain positive learning environments. These strategies are among those that nursing students in Australia have recognised as valuable for enhancing their learning experience in the clinical setting (Sweet & Broadbent, 2017), and among the strategies that are effective in preventing and addressing bullying in nursing (Luca et al., 2024).

Broader societal context

Finally, academics and CEs reflected on the diversity of Australian society and the continued prevalence of R&D. They noted that, despite existing laws and regulations, everyday racism appears to be normalised within the culture, allowing discrimination to remain deeply embedded. Factors such as age, physical appearance, and even the university a student attended, can influence job opportunities and promotions, sometimes leading to discrimination or preferential treatment. One Australian Caucasian CE highlighted a tendency among some

Australian-born individuals to dismiss those with language barriers or limited English proficiency, often assuming these individuals have diminished cognitive abilities. Although Australia has federal, state and territory laws to protect against discrimination and harassment – such as the *Racial Discrimination Act 1975* (Cth), which prohibits discrimination based on race, colour, descent, national origin, ethnic origin or immigrant status – racism and discrimination still appear to be a part of daily interactions.

6.5 Conclusion

This chapter presented the findings from three sets of interviews with regulatory and educational experts, academics, and clinical educators, along with a discussion of these findings in relation to the extended literature. The aim of this study was to explore the views of educational and regulatory experts in relation to the elements of IPCC in Australia, and to analyse the experiences of those elements in one school of nursing in relation to educational preparation and clinical practice. The core elements of IPCC were set out in the introduction: mutual collaboration and professional relationships; prevention of racism, discrimination, bullying and harassment among nurses; respecting values, attitudes and beliefs of colleagues that may differ across cultures; and responding appropriately to cross-cultural interactions with colleagues. Following the analysis of the results, experts highlighted the inclusion of these elements in regulatory documents, but also acknowledged the ongoing challenges in expanding the application of the elements of IPCC across nursing practice in Australia. Notwithstanding these concerns, it seemed to be evident that these core elements of IPCC were present in the BN curriculum and processes at this school of nursing.

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Chapter Seven

Discussion and conclusions

7.1 Introduction

Chapter Seven presents the discussion and conclusion of the thesis. It begins by acknowledging the study's limitations, followed by a triangulation of the findings across the four studies. The originality and significance of the thesis are then discussed, highlighting the development of a new concept—Intra-Professional Cultural Competence (IPCC)—which has the potential to improve workplace culture and benefit not only internationally qualified nurses (IQNs) but the broader nursing workforce in Australia.

The chapter then provides recommendations for nursing regulatory bodies, educational providers, and healthcare organisations. This is followed by a section on the implications for future research, and the chapter concludes with a summary of the main contributions of the thesis.

7.2 Triangulation of findings in each study

Internationally Qualified Nurses (IQNs) encounter various barriers and facilitators when integrating into the Australian workforce. This thesis explores this phenomenon from multiple perspectives, including clinical practice, regulatory frameworks and educational contexts, and proposes a potential strategy to support the integration of IQNs.

This study now takes an overview to consider the principal barriers and facilitators to integration and workplace culture, and to examine the relevant elements of workforce

diversity and professional dynamics, before addressing the potential usefulness of intra-professional cultural competence (IPCC) as a strategy.

Overview of Barriers and Facilitators to Integration and Workplace Culture

Study One – the systematic review – identified the main barriers and facilitators to the professional integration of IQNs, identifying personal and social factors that were consistent with previous studies conducted in Australia (Chun Tie et al., 2018; Konno, 2006; Ng Chok et al., 2018). In this first Study, it was found that a primary barrier to integration was the widespread presence of discrimination and racism within the Australian nursing culture, expressed in various ways (Correa-Betancour, Marcus, et al., 2024). These findings were confirmed to some extent in Study Four – the interviews with educational and regulatory experts, academics and clinical educators – where it was observed by participants that racism and discrimination (R&D) and bullying and harassment (B&H) persist as widespread challenges within the nursing profession globally, indicating that these issues are not solely rooted in cultural differences. However, contradictions were noted in some of the participants' responses regarding their perceptions and the identification of personal and vicarious experiences of R&D and B&H. These findings revealed a paradox: while the broader Australian literature emphasises the prevalence of such issues in nursing, the exploratory research conducted for this Study indicated that individuals often found it difficult to recall and articulate personal experiences when prompted. The paradox of R&D and B&H identified in this thesis represents an important contribution, as it has not been explicitly discussed in previous research. While most existing studies focus on describing instances of R&D and B&H, understanding its effects and developing preventative strategies, Study Four of this thesis offers a new perspective. Although exploratory in nature and based on a small sample, the findings underscore the importance of differentiating between personal or vicarious experiences of R&D and B&H, and encouraging research participants, when it is possible, to narrate these experiences. Given the sensitivity of these topics and the increased awareness and education around R&D and B&H, there is a risk that participants may conflate awareness

with lived experiences. Additionally, the potential for social desirability bias further complicates this issue. The senior nature of the nurses and/or their relatively powerful positions might have rendered them less-likely recipients of such behaviours or to be sought as confidants of those targeted. Future research should take these factors into account to gain a deeper and more accurate understanding of the complexities surrounding R&D and B&H within the nursing profession.

Workforce Diversity and Professional Dynamics

Additionally, despite the evidence for R&D and B&H highlighted in earlier research on IQNs, Study Four – the interviews with educational and regulatory experts, academics and clinical educators – revealed that various stakeholders in different nursing roles – the experts, the academics and the clinical educators – were aware of the challenges faced by IQNs and culturally and linguistically diverse students in everyday practice. For instance, the participants mentioned subtle discrimination in promotion processes affecting IQNs and colleagues from non-Caucasian backgrounds, and insufficient mentoring from supervisors was also noted as a potential systemic barrier to career advancement. This issue may be reflected in the lack of diversity within leadership roles, with the interviewees reporting that most nurse managers were Caucasian, despite the diverse composition of the nursing staff. The limited diversity within the academic faculty and in managerial roles has also been identified as an issue in other countries with a high proportion of IQNs (Iheduru-Anderson, 2020; Silver, 2017). However, in contrast to the findings of the Study One systematic review, Study Four – the interviews with educational and regulatory experts, academics and clinical educators – found that, when addressing R&D and B&H, all three groups interviewed expressed a strong commitment to upholding zero tolerance policies and practices, demonstrating a collective effort to foster a respectful and supportive environment.

Evidence of accent discrimination affecting IQNs was also found in the Study One systematic review and reported by some interviewees in Study Four. Accent discrimination occurs when individuals are judged based on their manner of speaking, rather than the content of their speech. This form of evaluation often activates racial stereotypes linked to the speaker's social identity (Cantone et al., 2019). Speech discrimination has been described in previous studies in Australia (New South Wales Nurses and Midwives' Association, 2019) and in other

countries with high rates of migration, such as the USA (Iheduru-Anderson, 2020; Moceri, 2014), Finland (Cubelo, 2023) and Canada (Boateng & Brown, 2022), and is not limited to the nursing profession (Baquiran & Nicoladis, 2020; Gu & Shah, 2019; Spence et al., 2024).

The normalisation and social acceptance of everyday racism and discrimination was identified in both Study One and Study Four. This may contribute to the perception that conduct associated with R&D and B&H are inherent aspect of the nursing profession. This normalisation may become embedded in the process of professional identity construction for IQNs and recently graduated LQNs, further perpetuating hostile work environments. The influence of work environment in professional identity construction was also reported by some interviewees in Study Four. According to Study Four findings, workplace culture and environment play a significant role in the prevalence of R&D and B&H, confirming that context was shown to be critical in shaping the professional identity of undergraduate nursing students, as it fosters connection with a peer community and alignment with a shared mission (Fagermoen, 1997; Rasmussen et al., 2018, 2021). This Study found that, despite significant educational efforts to address R&D and B&H, new graduates often quickly adapt to the existing institutional culture. In some cases, this leads to the adoption and perpetuation of these negative behaviours within clinical settings. These results support the conclusions of earlier research, which have found that the behaviours and interactions of practising nurses can significantly shape students' perceptions of the nursing role, further contributing to their professional identity (Rasmussen et al., 2018). Consequently, the professional identities of students and new graduates may be directly influenced by observing and mimicking workplace practices related to R&D and/or B&H. Addressing and interrupting this cycle is essential to prevent the perpetuation of such behaviours. In Study Four it was found that clinical educators employed key strategies that have proven to be effective in shaping a positive professional identity (Rasmussen et al., 2018; Zeng et al., 2022). These strategies include mentoring, role modelling, leading by example, fostering collaborative teamwork, and demonstrating professionalism and respect in interactions with nurses and other staff. Such approaches have the potential to instil positive values, behaviours and attitudes that are integral to non-discriminatory and constructive professional nursing culture and practice.

This thesis highlights the complexity of relationships among nurses. On the one hand, the systematic review in Study One revealed a reluctance among LQNs to engage in social

conversations with IQNs. Interactions were often limited to minimise risks and prevent misinformation, regardless of whether the nurses came from English-speaking or non-English-speaking backgrounds. On the other hand, Study Four participants identified (without criticism) the formation of cultural cliques among nurses who shared similar cultural backgrounds or languages. While these clusters provide a sense of belonging, they may restrict interactions between IQNs and LQNs, thereby hindering broader workplace integration. These findings identified the non-linear nature of these issues, and that conduct associated with R&D and B&H can be bi-directional and is not confined to the dominant culture within the workplace. This finding contributes to filling a gap in the current understanding of the complex relationships and dynamics between nurses. While much of the existing research focuses on R&D and B&H directed at IQNs, there is limited evidence exploring this alternative perspective in both national and international levels (Matahela, 2023; Powers et al., 2014; Woodhead et al., 2022) and in Australia (Johnstone, 2016). This observation opens a new avenue for research aimed at understanding the causes of such behaviours, developing strategies for prevention, and identifying effective approaches to address these behaviours within the nursing profession.

Study Four – the interviews with educational and regulatory experts, academics, and clinical educators – also revealed another complexity in the nature of R&D and B&H by exposing the existence of contra-power harassment directed at academics and clinical educators, reinforcing the findings of previous studies conducted in Australia (Cassum, 2018; Christensen et al., 2019).

In Study Two – the workforce data analysis – the cultural and linguistic characteristics of the nursing workforce in Australia were explored. It was found that 43% of the Australian nursing workforce was born overseas, many of whom presumably may have culturally and linguistically diverse backgrounds. While the proportion of IQNs in the workforce remained stable at approximately 22% between 2016 and 2022, the percentage of overseas-born locally qualified nurses (LQNs) rose from 16% in 2016 to 21% in 2022. These findings were reinforced by the findings from the interviews conducted in Study Four, in which it was observed that the Australian nursing workforce is increasingly diverse and has begun to reflect the multicultural composition of Australian society. This diversity is expected to grow further in the coming years due to the rising number of international students enrolled in nursing

programs across Australia. This is a highly positive finding as a more diverse nursing workforce can enhance access to quality healthcare and contribute to achieving greater health equity. Research has shown that racial or ethnic concordance between patients and healthcare providers is associated with higher levels of perceived patient satisfaction, improved quality of care and greater trust in healthcare providers (Moore et al., 2023). The lack of diversity in the nursing workforce has been recognised as a public health issue in the USA, leading to the implementation of targeted initiatives aimed at increasing the diversity of the student population in schools of nursing (Nickitas et al., 2022; Noone et al., 2020; Spencer, 2020).

Intra-professional Cultural Competence (IPCC) as a Strategy

While the primary aim of Study Two was to explore the workforce data, it also devised the concept of intra-professional cultural competence (IPCC) and proposed it as a strategy to support nurses from culturally and linguistically diverse backgrounds, including both IQNS and overseas-born LQNs. Intra-professional cultural competence was suggested to positively influence communication, teamwork, mutual respect and the prevention of situations related to R&D and B&H within the nursing profession. Intra-professional cultural competence remains a theoretical concept and has not yet been empirically validated; however, there is evidence of the benefits that education regarding cultural competence can have on nurse–patient relationships (Chae et al., 2020; Renzaho et al., 2013; Vella et al., 2022) and also the benefits for nurses of having good work environments (Joensuu et al., 2024; Thomas & Lee, 2024; Ulrich et al., 2019).

Study Three investigated the approach taken by regulators to address the barriers and facilitators to the professional integration of IQNs in Australia, and the effectiveness of this approach, using the elements of IPCC as the criteria for investigating the documents. It was identified that key nursing regulatory documents – the Code of Conduct and the Standards for Practice – have served to some extent as facilitators for the professional integration of IQNs and contain elements aligned with the concept of IPCC. A comparison with regulatory documents from other countries revealed that Australia's regulatory framework – especially the Code of Conduct – addresses critical issues such as communication, professional relationships, the prevention of bullying and harassment, and cultural respect, all of which are core elements of IPCC. This analysis, along with the international comparisons,

contributes to the field of nursing scholarship by advancing understanding of the scope and role of regulatory documents in fostering professional conduct and cultural respect. These findings were reinforced in the interviews in Study Four, in which interviewees acknowledged that regulatory updates have been instrumental in shaping the nursing profession over time and addressing contemporary challenges.

However, the findings in **Studies Three** and **Four** also highlight a gap between the principles outlined in regulatory documents and the persistence of everyday behaviours associated with R&D and B&H within the nursing profession. At the same time, regulatory documents were observed to serve as a powerful mechanism for delivering consistent messages across the extensive network of practitioners. This approach could be particularly strategic to promote the elements of IPCC within nursing education and accreditation frameworks. Regarding the effectiveness of this approach, as was found in Studies One and Four, it has not been entirely effective, particularly in addressing issues such as communication challenges or incidents linked to R&D and B&H.

Study Four focused on exploring the views of regulatory experts in relation to the elements of IPCC in Australian regulatory documents, and the views of academics and clinical educators of one school of nursing regarding the elements of IPCC in relation to educational preparation and clinical practice. In this Study, the role of the accreditation standards in establishing a foundational framework for educational quality and professional practice was acknowledged. A comparison between the Australian Nursing and Midwifery Accreditation Council (ANMAC) standards (ANMAC, 2019) and the USA Commission on Collegiate Nursing Education (CCNE) Standards for Accreditation of Baccalaureate and Graduate Nursing Programs (Commission on Collegiate Nursing Education, 2024) reveals that the ANMAC standards have a more comprehensive approach to including the elements of IPCC in the curriculum. For example, both frameworks require educational institutions to prepare students to provide care to diverse individuals and populations and to prepare students for interprofessional practice. However, the ANMAC standards uniquely mandate the integration of principles of intra-professional learning and practice, as well as the inclusion of Aboriginal and Torres Strait Islander peoples' history, culture and health throughout the program. These specific requirements or similar in relation to First Nations people in the USA are not explicitly outlined in the CCNE standards.

The interviews with educational and regulatory experts, academics and clinical educators in Study Four highlighted the challenges associated with implementing a comprehensive curriculum that meets accreditation standards, as such implementation does not always result in meaningful or practical content application. There appears to be significant variability in the content included in curricula and the extent to which this content is applied in real-life educational settings, despite the existence of accreditation standards. These findings contribute to the existing knowledge about the accreditation process and its application in nursing education, providing insights into the perspectives of various stakeholders on these processes. Future research could further explore the actual variability across curricula and, more specifically, examine how elements of IPCC are incorporated and taught in different educational contexts.

Significant diversity within the student population was identified in the workforce data analysis in Study Two and the interviews in Study Four, with a notable increase observed in the representation of various cultural and linguistic backgrounds in recent years. These groups enrich the educational environment by contributing diverse cultural perspectives and experiences. But it was reported in Study Four that the inclusion of international students, particularly those with culturally and linguistically diverse backgrounds has also introduced certain challenges. They often encounter additional difficulties that may adversely affect their mental health and self-esteem, thereby hindering their ability to integrate successfully. These outcomes correspond with previous findings in Australia that identified communication barriers (Graham et al., 2024), difficulties in understanding colloquialisms and clinical jargon (Abu-Arab & Parry, 2015; Graham et al., 2024; Lim et al., 2023; Lin et al., 2021) and differences in communication styles (Abu-Arab & Parry, 2015).

The findings from Study Four also revealed that experts, academics and clinical educators are fully aware of the challenges faced by international students and, within their respective roles, make significant efforts to support the integration of these students. Clinical educators, in particular, emphasised the importance of being mindful of the needs of CALD students to provide adequate support during clinical placements. This aligns with previous research, which found that such actions positively influence CALD students' perceptions of support and integration (Lin et al., 2021). Furthermore, many of the strategies reported by clinical educators in this Study are consistent with evidence-based practices shown to effectively

support CALD students in clinical settings. These strategies include creating a non-judgemental environment, using clear and direct communication, understanding potential language difficulties, helping students manage expectations, and conducting regular debriefing sessions (Lin et al., 2021). These efforts play a critical role in fostering a supportive and inclusive clinical learning environment for CALD students.

Experiences of R&D and/or B&H during nursing students' clinical placements were also reported in Study Four. These findings validate the conclusions of prior studies that found evidence of public humiliation or verbal abuse (Birks et al., 2017; Budden et al., 2017; Graham et al., 2024), and being excluded from learning opportunities (Birks et al., 2017; Budden et al., 2017; Graham et al., 2024). Reports of physical aggression have also been documented (Birks et al., 2017; Hopkins et al., 2014), alongside instances of indirect and subtle forms of racism and discrimination (Birks et al., 2017; Budden et al., 2017; Graham et al., 2024). These behaviours can stem from various sources (Birks et al., 2017; Budden et al., 2017; Graham et al., 2024; Hopkins et al., 2014) and may also arise from staff members from different multicultural backgrounds, often driven by conflicts within their home countries (Graham et al., 2024).

Despite this evidence, the findings of Study Four highlight a distinct attitude towards R&D and B&H among the participants. In their responses, they recalled implementing numerous strategies, which have been proven to be effective, in their everyday practice to support students from culturally and linguistically diverse backgrounds. For instance, academics incorporate these topics into simulation scenarios, create intentional opportunities for cultural discussions (Registered Nurses' Association of Ontario, 2019; Wu et al., 2019), and encourage self-reflection on privilege, fostering an understanding of diverse perspectives (Mayoum et al., 2022). Additionally, clinical educators implement targeted practices to support and promote inclusion. These practices include educating students about the various forms of R&D and B&H, explaining procedures for escalating such situations, and guiding group and individual discussions (Registered Nurses' Association of Ontario, 2019).

Findings from the interviews in Study Four highlight the importance of supporting students from culturally and linguistically diverse backgrounds in practising in a culturally safe manner, fostering their adaptation to the Australian context, while ensuring their cultural identities

are respected and preserved. This is particularly significant, because much of the existing research tends to focus on the assimilation of international students and their acceptance within educational settings and broader society. In contrast, this Study offers a new perspective, encouraging all students, including those from culturally and linguistically diverse backgrounds, to adopt culturally competent practices, even though they belong to a non-dominant group.

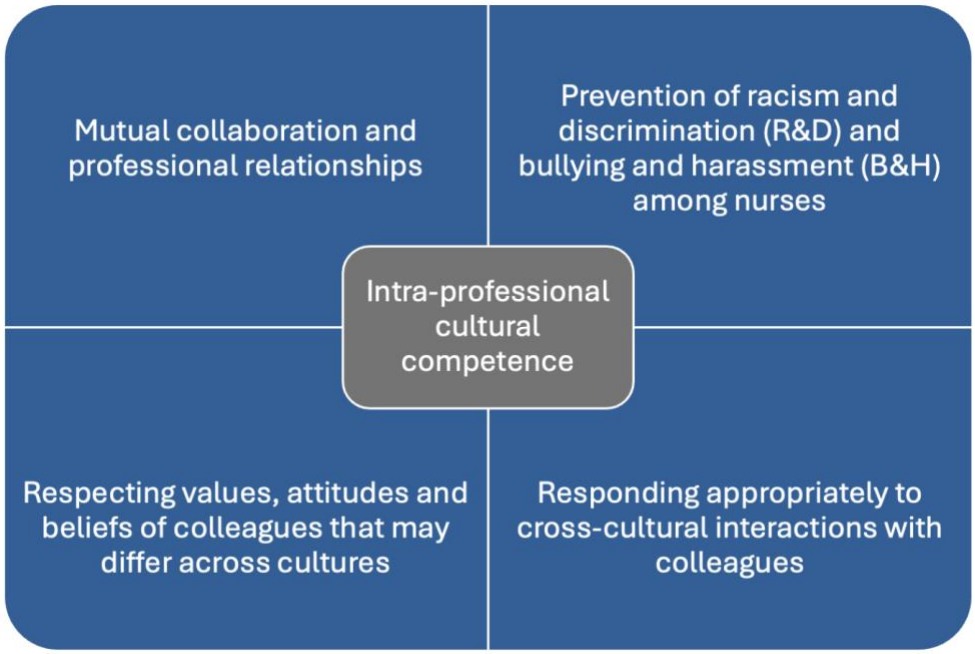
While this was not the primary focus of this thesis, it is important to acknowledge that R&D and B&H are not solely rooted in cultural differences (Amis et al., 2018, 2020; Bapuji, 2015). Social and economic inequalities—often embedded within the bureaucratic structures of large organisations—also play a significant role. Organisational practices related to hiring, role allocation, promotion, compensation, and institutional structuring have been identified as central mechanisms in the reproduction of inequality (Amis et al., 2018, 2020). These structural inequalities can exacerbate both formal and informal expressions of R&D and B&H, contributing to the persistence of such behaviours within the nursing profession globally (Debesay et al., 2022; Iheduru-Anderson, 2020). The International Council of Nurses in a Position Statement on Health Inequities and Discrimination in Nursing (2023) acknowledges this (International Council of Nurses, 2023).

7.3 Originality and significance

The originality and significance of this thesis lies in the development of a new concept – intra-professional cultural competence – which has the potential to serve as a strategy for improving workplace cultures, benefiting not only IQNs but all nurses working within the Australian context.

The concept of IPCC focuses on the relationships between nurses, particularly those from different cultural and/or linguistic backgrounds, such as locally qualified nurses (LQNs overseas or Australian-born) and internationally qualified nurses (IQNs). The concept of IPCC was broken down into key elements, and its theoretical benefits were outlined. Figure 7.1 shows the elements of IPCC.

Figure 7.1. Elements of intra-professional cultural competence



Source: Made by the candidate based on data of Correa-Betancour, Chiarella, et al. (2024).

While ***intra-professional*** cultural competence remains a theoretical concept, with its specific effects yet to be empirically validated, there is existing evidence that cultural competence training enhances practitioners' knowledge, awareness and sensitivity, particularly in relation to their interactions with their patients (Chae et al., 2020; Renzaho et al., 2013; Vella et al., 2022). Furthermore, such training has been shown to improve patient satisfaction and trust (Govere & Govere, 2016; Tang et al., 2019; Vella et al., 2022).

Evidence of the elements of IPCC was found in Studies Three and Four. Study Three – the examination of regulatory documents – highlighted the significance of mutual collaboration and professional relationships, as reflected in the Nursing and Midwifery Board of Australia (NMBA) registered nurse (RN) Standards for Practice, which stress the value of therapeutic and professional relationships and collegial generosity. Similarly, the NMBA Code of Conduct for Nurses emphasises clear, effective and accurate communication among colleagues and the importance of fostering a positive workplace environment. Good working environments and intra-professional collaboration have been associated with job satisfaction (Joensuu et al., 2024; Thomas & Lee, 2024; Ulrich et al., 2019), nurse retention (Thomas & Lee, 2024; Ulrich et al., 2019), the delivery of high-quality care (Schön Persson et al., 2018; Ylitörmänen

et al., 2023), team cohesion and overall wellbeing (Ylitörmänen et al., 2023). Clear communication is particularly critical in nursing for maintaining high standards of care, ensuring patient safety and preventing fatalities (Raeisi et al., 2019). This is especially vital in multicultural teams, which are common within the Australian nursing workforce. Conversely, negative work environments are associated with higher levels of burnout, intention to leave the current workplace, increased infection rates, medication errors, and patient and family complaints (Dordunoo et al., 2024).

Study Four also identified the importance of mutual collaboration and professional relationships, emphasised through specific strategies employed by clinical educators during clinical placements. These strategies included fostering teamwork, demonstrating professionalism in interactions with colleagues, and treating others with respect. Such strategies were found to play a pivotal role in shaping a positive professional identity (Rasmussen et al., 2018; Zeng et al., 2022). Additionally, Study Four revealed that clinical educators prioritised instilling teamwork values, reinforcing culturally sensitive practices, and ensuring effective, direct communication to create positive learning environments. These strategies align with those recognised by Australian nursing students as enhancing their clinical learning experience (Sweet & Broadbent, 2017), and are considered effective in preventing and addressing bullying in nursing (Luca et al., 2024).

The examination of regulatory documents in Study Three -the examination of regulatory documents- highlighted the prevention of racism and discrimination (R&D) and bullying and harassment (B&H) among nurses. While the NMBA RN Standards for Practice in Australia do not explicitly mention the prevention of R&D and B&H, suggesting an oversight in tackling these critical challenges, the NMBA Code of Conduct for Nurses explicitly requires the prevention of R&D, emphasising respect for diversity and avoidance of bias. Despite these clear directives, the literature frequently identifies R&D and B&H as barriers to the professional integration of internationally qualified nurses (IQNs) in Australia (Dywili et al., 2021; Joseph et al., 2022; Mapedzahama et al., 2018; Philip, Woodward-Kron, & Manias, 2019; Philip, Woodward-Kron, Manias, & Noronha, 2019; Zanjani et al., 2021). These behaviours may reflect a broader societal normalisation and acceptance of such issues (Dywili et al., 2021; Mapedzahama et al., 2018).

The prevention of R&D and B&H among nurses was also explored in Study Four, with these issues recognised as pervasive challenges within the nursing profession worldwide. This perspective aligns with existing global evidence on the prevalence of R&D (Cubelo, 2023; Gauci et al., 2023; Iheduru-Anderson, 2020; Tuttas, 2015; Wijayaratnam et al., 2024) and B&H (Goh et al., 2022; Jones, 2017; Karatuna et al., 2020; Shorey & Wong, 2021).

The Study Four findings acknowledge the challenges faced by IQNs, including subtle discrimination, barriers to promotion and the formation of cultural cliques. While previous research has documented the difficulties IQNs encounter in Australia (Chun Tie et al., 2018; Correa-Betancour, Marcus, et al., 2024; Ng Chok et al., 2018), no evidence was found regarding discrimination originating from non-dominant groups within nursing. Additionally, the study revealed that CALD students experience challenges in clinical settings, consistent with prior research (Abu-Arab & Parry, 2015; Birks et al., 2017; Budden et al., 2017; Graham et al., 2024; Hopkins et al., 2014; Lim et al., 2023; Randon et al., 2020).

Simultaneously, participants in Study Four identified several strategies to prevent R&D and B&H, including facilitating cultural discussions to promote awareness, expand understanding, reflect on personal biases, and appreciate diverse perspectives and worldviews. In clinical settings, reflective practice was central to these efforts, particularly through debriefing sessions. Clinical educators played a key role by leading discussions, clarifying misconceptions, encouraging critical thinking, and fostering reflection in a supportive, respectful and open environment. These findings are consistent with existing literature, which emphasises that providing spaces for sensitive and relational conversations enables critical reflection and collaboration to address and prevent issues such as racism and bullying (Luca et al., 2024; Mayoum et al., 2022).

The examination of regulatory documents in Study Three found that the NMBA RN Standards for Practice address the concept of respecting the values, attitudes and beliefs of individuals from different cultures, but do not explicitly distinguish between colleagues and patients. The emphasis is primarily on the health of Aboriginal and Torres Strait Islander peoples and individuals from diverse cultural backgrounds. In contrast, the NMBA Code of Conduct for Nurses explicitly includes this content, clearly referring to both patients and colleagues.

In Study Four, the academics recognised the challenges that IQNs face in clinical settings, particularly the cultural differences. These challenges, documented in previous research, include the need for acculturation, language and communication barriers, variations in nursing roles and scope of practice, as well as experiences of R&D and B&H, among others (Chun Tie et al., 2018; Correa-Betancour, Marcus, et al., 2024; Ng Chok et al., 2018).

With regards to responding appropriately to cross-cultural interactions with colleagues, Study Three found that the NMBA Code of Conduct for Nurses contains this content and highlights the importance of cultural safety for patients and families, while also incorporating principles that uphold the rights, dignity and safety of colleagues. The Code advocates for mutual collaboration, the prevention of discrimination, respect for cultural differences, and the creation of a positive and inclusive professional environment for both patients and colleagues. Finally, in Study Four, experts noted that academic calendars and current curricular structures often fail to accommodate the cultural and religious needs of students and staff during important events, highlighting a gap in fostering inclusivity.

It can be seen that, although IPCC *per se* has not been identified or discussed as a concept before, the elements of IPCC are present in both nursing regulatory documents and the minds of nursing experts, academics and clinical educators. Formalising the notion by bringing the elements together into a named concept may assist in raising the need for the elements to be lived out in Australian nursing practice.

The adoption of IPCC as an educational tool represents a significant advancement for the nursing profession. Integrating it into a framework that directly addresses important issues in nursing practice and interpersonal interactions could benefit all nurses, fostering a proactive approach to inclusivity and collaboration. The introduction of IPCC lays the foundation for future research to assess its effectiveness and refine the concept for adaptation to diverse contexts where nurses and other health professionals perform their roles.

7.4 Recommendations

This section will offer some recommendations to implement intra-professional cultural competence as a tool to facilitate the professional integration of IQNs and LQNs.

Before presenting the recommendations, I would like to reaffirm my position as an IQN in Australia. After residing in this country for three years, I may have developed a deeper understanding of both the nursing culture and the broader Australian society. The recommendations I am about to provide are derived from the findings of my research and the gaps that I identify due to my personal experiences as an international PhD candidate, a foreigner adapting to a new society, and as an IQN with a CALD background.

The recommendations are organised into three main sections relevant to:

1. Nursing regulatory nursing bodies
2. Educational providers
3. Healthcare organisations

7.4.1 Recommendations for regulatory nursing bodies

Nursing regulatory bodies may have an important role in incorporating the elements of intra-professional cultural competence into regulatory documents and practice to contribute to the creation of more inclusive workplace environments. Some of the recommendations for nursing regulatory bodies are:

a. **To reinforce and/or establish clear statements that explicitly prohibit racism and discrimination and/or bullying and harassment in nursing regulatory documents.** This may be beneficial in raising awareness, and in preventing and addressing such issues. In the Australian context, the NMBA Code of Conduct contains some elements of IPCC; however, it could be more explicit regarding the intra-professional nature of the expected behaviour. Furthermore, the NMBA RN Standards for Practice do not specifically address the prevention of R&D and/or B&H, focusing solely on communication. There is also no explicit mention of the importance of respecting the values, attitudes and beliefs of colleagues from diverse cultural backgrounds. This thesis would support these recommendations to use the term “colleagues” instead of “person” to make it explicit and clear and to reinforce the principle of mutual respect within the workplace.

   In relation to the **Code of Ethics**, the International Council of Nurses (ICN) Code of Ethics, which was adopted for Australian nurses and midwives from 1 March 2018 and updated in 2021, does not directly address the prevention of R&D and/or B&H (ICN,

2021). The text outlines two key principles: upholding high standards of personal conduct, and actively contributing to the professional growth of others. This involves sharing knowledge and expertise, offering feedback, mentoring, and supporting the development of student nurses, novice nurses, colleagues and other healthcare professionals. As R&D and/or B&H are global issues in nursing practice, it would be beneficial to explicitly include this information as an independent statement to make the zero tolerance policy more evident and present in every nursing regulatory document. As an example, the American Nurses Association Code of Ethics does include a statement addressing the need for good intra-professional relationships and collaboration, and it also explicitly advocates for the prevention of and zero tolerance towards bullying, harassment, intimidation, manipulation, threats or violence (American Nurses Association, 2015).

Similarly, the Australian Nursing and Midwifery Accreditation Council's (ANMAC) Accreditation Standards contain information regarding intra-professional learning and practice and incorporating principles of diversity, culture, inclusion and cultural safety for everyone. However, there is no explicit mention of the necessity for nurses to apply these principles in their interactions with colleagues. Likewise, although the ANMAC Accreditation Standards acknowledge the significance of good mental health in Australia and mandate its inclusion in nursing curricula, they do not explicitly link this to the prevention and reporting of practices that may have a detrimental impact on nurses' mental health, such as R&D and/or B&H. It would contribute positively if the ANMAC Accreditation Standards included an explicit statement incorporating the application of these principles to colleagues and the importance of preventing practices linked to R&D and/or B&H in nursing education.

b. **To address the variability within nursing curricula across different providers in the accreditation process.** As identified in the Study Four from the interviews with experts, academics and clinical educators, there may be a lack of uniformity in the delivery of curriculum content related to the elements of IPCC. Additionally, other areas that may require enhancement were identified, such as improving the follow-up process for addressing weaknesses or areas of improvement highlighted during accreditation. Additionally, ensuring consistency in the delivery of content across all

areas is crucial to maintain quality and alignment with standards. One strategy to ensure consistency in the delivery of content could be to establish a stand-alone requirement for IPCC that contains the minimum content to be included in nursing curricula regarding the elements of IPCC. This approach could be similar to the approach taken to address the healthcare needs relevant to Aboriginal and Torres Strait Islander peoples (ANMAC, 2019).

c. **To ensure consistency in IQNs' knowledge and understanding of the elements of IPCC during the registration process.** In the registration process for IQNs, there is currently an orientation module that serves as an introduction to the Australian healthcare system (NMBA, 2022, 2024). It would be beneficial to explicitly include in this orientation program a module on the elements of IPCC, covering the importance and benefits of its application, and the legal and ethical implications. This module could reinforce the aspects of the NMBA Code of Conduct, NMBA Standards for Practice, ICN Code of Ethics and the Australian legislation that are related to the prevention of R&D and/or B&H in the workplace. This module should also provide a wide range of examples illustrating the different forms that R&D and/or B&H may take in the workplace to help IQNs recognise and/or avoid such situations. Furthermore, it should include content on the importance of reporting these incidents and the appropriate procedures for doing so. This would be particularly advantageous, considering that IQNs from various cultural backgrounds may not be aware of the reporting process, may perceive reporting as inappropriate or as a source of conflict with managers, or may simply lack knowledge on how to defend themselves or speak up in uncomfortable situations.

   In addition to ensuring consistent preparation for the Australian healthcare context, it is recommended to introduce mandatory IPCC training at regular intervals as part of the renewal process for RN registration. Incorporating this as part of the continuing professional development requirements for RNs would contribute to creating safer and more respectful workplaces.

7.4.2 Recommendations for educational providers

Providers of nursing education programs would benefit from implementing standardised strategies to incorporate the elements of IPCC. Some of the recommendations for educational providers are:

a. **To integrate targeted content on the elements of IPCC throughout the nursing curriculum.** For instance, incorporating content on cultural diversity in nursing and its benefits for patient care, and educate on how to recognise and report R&D and/or B&H (Federation of Ethnic Communities' Councils of Australia (FECCA), 2024; Registered Nurses' Association of Ontario, 2019). As was demonstrated in the interviews in Study Four, incorporating education about these situations as a requirement in the nursing curriculum could help shift the perception of R&D and/or B&H (in some instances) as an acceptable aspect of nursing culture to being recognised as intolerable and unprofessional behaviour (Rutherford et al., 2019). This approach emphasises the harmful impacts of bullying on victims and witnesses (Báez-León et al., 2016; Cardoso et al., 2016; Holm et al., 2023; Hong et al., 2022) and may help to cement a culture of zero tolerance.

   Several strategies that have been proven to be effective in educating about bullying, and which can be equally valuable for addressing R&D and harassment, include problem-based learning, journalling perceptions and experiences, and cognitive rehearsal. Cognitive rehearsal, in particular, serves as a tool for mental organisation, helping individuals build confidence and develop positive thinking patterns (Egues & Leinung, 2014). Integrating lectures, case-based learning and simulation activities may significantly enhance students' cultural competence and presumably IPCC (Qin & Chaimongkol, 2021).

b. **To create intentional opportunities for discussions in safe spaces** (Egues & Leinung, 2014). Training in assertive communication has been shown to reduce workplace bullying and verbal abuse (Ceravolo et al., 2012) and to foster a more respectful and supportive work environment (Asi Karakaş & Okanli, 2015).

   This is particularly important for encouraging students to understand and appreciate diverse perspectives and worldviews, as well as to reflect on their own privilege and

societal structures (Mayoum et al., 2022). Additionally, incorporating simulation activities to educate students about cultural differences, encourage self-reflection on personal biases, and recognise and respond to instances of R&D and/or B&H through guided responses could also be highly beneficial (Registered Nurses' Association of Ontario, 2019; Wu et al., 2019).

c. **To implement annual awareness campaigns within educational institutions.** These campaigns could help prevent, address and encourage reporting of R&D and/or B&H in nursing, as well as promote an understanding of the detrimental effects of such practices on victims and witnesses. The campaigns could be conducted through seminars, workshops and intercultural events within nursing schools.
d. **To target support for students from CALD backgrounds**. International students pursuing their degrees at Australian universities face a wide range of challenges that should be addressed more adequately to support their success, not only within their undergraduate programs but also in their transition into the workforce. To begin with, language and communication support and training should be implemented (Centre for Cultural Diversity in Ageing, 2022, 2024). This could include language proficiency courses and communication workshops specifically tailored for international students, aimed at enhancing their interactions with patients and colleagues, with a particular focus on the use of colloquialisms and clinical jargon commonly used in the Australian healthcare context. These strategies may be valuable for achieving a nursing workforce that mirrors more closely the diversity of the community. This aligns with the strategic plans of governmental organisations such as NSW Health, which place importance on the attraction and retention of workers from CALD backgrounds (New South Wales [NSW] Ministry of Health, 2022).
e. **To implement mentorship programs for international students, involving either local or other international students.** These programs could assist international students in navigating and understanding cultural differences, comprehending what is expected of them in their roles, and learning from the experiences of other students who may have faced similar challenges. Mentorship between nursing students at different experience levels has demonstrated positive impacts on academic (Kramer et al., 2018; Miller et al., 2019; Sibiya et al., 2018), personal and professional development

(Miller et al., 2019). Furthermore, it fosters an emotionally supportive environment, helping mentees reduce stress while boosting their confidence and competency (Kramer et al., 2018; Sibiya et al., 2018). In this context, it is essential to recognise that a mentor's cultural competence is influenced by factors such as work experience, age, job title and the frequency of mentoring (Luukkonen et al., 2023). These factors should be carefully considered when selecting a mentor for this role.

f. **To increase the inclusion of academics or clinical educators from CALD backgrounds.** This could help promote the value of diversity, serve as role models for students and enhance tolerance, particularly in terms of different accents. However, such inclusion should be supported by organisational measures to ensure successful integration into the university work environment and alignment with academic responsibilities and expectations. This support could be delivered through mentorship initiatives that pair tenured, mid-career and early-career faculty members. Such programs have proven effective in fostering collaboration, sharing experiences and providing valuable support to colleagues (Webber et al., 2020). Pairing experienced and middle-career academics with academics from CALD backgrounds may facilitate knowledge exchange, organisational integration and acculturation (Mokel et al., 2022).
g. **To incorporate key areas of research in nursing research related to the elements of intra-professional cultural competence.** Institutions should encourage research on (for instance) the experiences of CALD students and IQNs, the prevention of R&D and/or B&H, or the effects of work environment on students' learning outcomes and professional identity, incorporating the findings into targeted educational strategies and policies.

7.4.3 Recommendations for healthcare organisations

There are several recommendations that could assist healthcare organisations to incorporate the elements of IPCC to improve the professional integration of IQNs, nurses from CALD backgrounds and LQNs to contribute to the creation of more inclusive workplace dynamics. Some of these recommendations for healthcare organisations are:

a. **To implement mandatory IPCC training as an integral component of in-service training for nurses.** This program could be delivered online or through interactive

workshops, with the aim of promoting respectful communication, fostering cultural awareness about the existence and prevention of R&D and/or B&H in nursing, addressing unconscious biases, and reminding staff about the harmful impacts of such behaviours.

b. **To develop and/or more strongly enforce organisational policies that prioritise inclusivity, equity and a zero-tolerance approach to R&D and/or B&H**. Numerous initiatives have been implemented to improve the recruitment and retention of healthcare workers from culturally and linguistically diverse (CALD) and Aboriginal and Torres Strait Islander (ATSI) backgrounds and from other diversity groups, aiming to better reflect the composition of Australian society. Most of these efforts are broad in scope, focusing on increasing diversity across the health workforce generally (Department of Health, 2025; Department of Health and Age Care, 2025; New South Wales Health, 2025; Queensland Health, 2023). The National Nursing Workforce Strategy, discussed in Chapter One is notable, as it is a national initiative that specifically focuses on diversifying the nursing workforce (Department of Health and Age Care, 2024).

Although the Australian legal framework addresses this issue, and although some organisations are highly active in this space, organisations could further strengthen understanding and compliance by providing targeted information and education. For example, awareness campaigns could be implemented to clearly outline the various forms that R&D and/or B&H can take, emphasise the consequences of such behaviours, and actively discourage potential offenders. These initiatives should also encourage reporting by fostering a safe and supportive environment for individuals to come forward with concerns. In addition, to reinforce these efforts, more organisations could establish inclusion committees comprising nurses and other health professionals from diverse positions, age groups and CALD backgrounds. These committees would play a pivotal role in promoting inclusivity, ensuring representation, and driving initiatives that cultivate a respectful and equitable workplace environment.

c. **To implement targeted strategies to attract, hire and retain a workforce that mirrors the diversity of the patient population.** Building a more diverse healthcare workforce

enhances cultural competence and improves the ability to meet the needs of an increasingly diverse population (Silver, 2017). Having a healthcare workforce that reflects the diversity of the community is a key priority for institutions in Australia (FECCA, 2024; NSW Ministry of Health, 2022). Healthcare workers from multicultural backgrounds often possess a deeper understanding of their communities, which can enhance the delivery of meaningful and effective care to the population (NSW Ministry of Health, 2022).

When working with the CALD nursing workforce, it may be important to implement strategies that support effective integration. These include identifying and gathering information about workplace diversity, recognising and accommodating cultural needs such as religious practices, promoting cross-cultural communication, and fostering inclusive workplaces by addressing R&D and/or B&H (Centre for Cultural Diversity in Ageing, 2024). Furthermore, providing support and training for bilingual staff is crucial to maximise their contributions (Centre for Cultural Diversity in Ageing, 2022).

d. **To establish confidential and accessible channels for reporting incidents of R&D and/or B&H, which ensure protections against retaliation, and provide clear procedures for investigation and resolution.** Initiatives designed to enable the anonymous reporting of health and safety concerns in the workplace are already being implemented in Australia (Australian Government, n.d.; New South Wales Government, 2020). For example, the Speak Up Save Lives app, developed by SafeWork NSW, enables individuals to report such issues anonymously (New South Wales Government, 2020). Similarly, the Fair Work Ombudsman offers an online platform for anonymously addressing workplace concerns, including safety-related matters (Australian Government, n.d.).

   Closely related to this, **implementing a system to monitor and evaluate the organisational climate** through surveys and audits would help identify areas for improvement in supporting nurses and reinforce the elements of IPCC. Additionally, this could serve to collect data on workplace incidents, and this information could be used to inform actions to create a supportive work environment.

Additionally, another strategy that could help collect feedback would be to support initiatives such as town halls, suggestion boxes and open-door policies. Utilising apps and online platforms could also provide effective means for reporting incidents using a QR code and offering support. Such strategies aim to foster transparency and trust between staff and management and could be useful to facilitate the reporting of incidents in an anonymous manner, particularly for individuals who are more familiar with technology. These technological solutions are already being utilised in other countries where mobile apps enable the anonymous reporting of workplace incidents (STOPit Solutions, 2024).

e. **To boost managers' commitment**. The commitment of managers and nursing leaders may be essential to promote healthy work environments (Mabona et al., 2022), to prevent instances of R&D and/or B&H (FECCA, 2024) and to promote inclusion (NSW Ministry of Health, 2022; Rutherford et al., 2019). Managers must actively demonstrate dedication to fostering diversity, by modelling inclusive behaviours and addressing issues promptly. Such efforts are crucial for improving the workplace environment, which will, in turn, encourage positive engagement and responses from healthcare workers (Registered Nurses' Association of Ontario, 2019). Managers who are approachable, supportive and proactive in implementing measures to prevent workplace violence contribute significantly to nurses feeling safer in their work environment (Cashmore et al., 2016).

   The Nurse Leader Core Competencies outlined by the American Organisation for Nursing Leadership highlight essential skills and qualities for effective leadership. These include managing conflicts constructively, building and maintaining a diverse workforce, ensuring a positive work environment, and addressing unconscious and systemic biases in organisational operations (American Organisation for Nursing Leadership, 2022). Leaders are also expected to champion initiatives that tackle racism, discrimination and bias in care delivery and business practices, while fostering an inclusive workplace where diversity and individual differences are valued and leveraged to achieve the organisation's vision and mission (American Organisation for Nursing Leadership, 2022).

It has been identified as crucial to provide leaders with formal training, appropriate support, and the necessary skills and resources to effectively address issues of harassment and bullying within healthcare organisations and academic institutions (Registered Nurses' Association of Ontario, 2019).

Hospitals with higher representation of racial and ethnic minorities in leadership roles tend to show a stronger dedication to diversity initiatives. Conversely, hospitals under the leadership of women, particularly white women, were associated with fewer diversity efforts (Herrin et al., 2018). It is important to recognise that candidates with CALD backgrounds may face additional barriers in accessing managerial roles. To address the challenges for these candidates, mentorship programs play a vital role in facilitating career progression and supporting their professional development (Silver, 2017). In this context, implementing a mentoring program to support new leaders in their roles could be highly beneficial (Hedenstrom et al., 2023). Such a program would contribute to providing guidance, fostering skill development, and helping build new leaders' confidence as they navigate the challenges of leadership.

Policies oriented to reducing instances of R&D and/or B&H are challenging to implement consistently and effectively when managers do not support for these policies or fail to fully understand and endorse them (Johnson et al., 2015). Additionally, managers should also be aware that the absence of directly hearing or witnessing harassing or bullying behaviours does not necessarily mean that such behaviours are not occurring.

f. **To utilise validated risk assessment tools**. This may be an effective approach to preventing and addressing R&D and/or B&H. These tools have proven useful in assessing violence among peers (Nemeth et al., 2017). Additionally, specific tools have been identified to detect incivility directed at students by staff nurses during clinical placements (Registered Nurses' Association of Ontario, 2019).
g. **To implement a formal incident review process to be conducted immediately following a violent event.** This process should involve a detailed discussion of the incident, the response strategies employed, and the development of actionable strategies to prevent similar occurrences in the future. Including participants from the

previously mentioned inclusion committee in these discussions could be highly beneficial. However, it would be crucial to maintain confidentiality for both the victim(s) and perpetrator(s) throughout the process to foster trust and encourage open dialogue (Registered Nurses' Association of Ontario, 2019).

h. **To establish mentorship and support programs.** These programs should specifically target all newly graduated nurses and IQNs entering the workforce to support their transition into the workforce. Such programs could provide support and guidance, reduce feelings of isolation, and promote career development among underrepresented groups. Moreover, they could help prevent the perpetuation of practices related to R&D and/or B&H in nursing, which appear in some workplaces to be embedded in professional identity. This issue was observed in Study Four and mentorship and support programs could be a critical element in breaking the cycle of such practices. Mentoring has been shown to have a positive impact on formal learning by providing academic and emotional support while serving as a platform for knowledge sharing (Yarbrough & Phillips, 2022). It also benefits mentees by boosting their confidence and competency, as well as alleviating anxiety and stress (Yarbrough & Phillips, 2022).

i. **To encourage nursing unions to also play a significant role in preventing R&D and/or B&H among nurses and in creating more inclusive workplaces.** For instance, unions can advocate for policies that protect nurses from R&D and/or B&H and ensure that legal frameworks support safe and equitable working conditions, while safeguarding nurses that have been victims of these practices.

7.5 Implications for future research

Given that this thesis has aimed to make an original and significant contribution to nursing scholarship, some directions for future research are considered below.

First, as the concept of intra-professional cultural competence (IPCC) was developed during this thesis, it remains a conceptual framework that has yet to undergo rigorous empirical validation. A key avenue for future research would involve validating its effectiveness. For instance, future studies could explore the elements of intra-professional cultural competence among nurses both before and after implementing a training program focused on the core

elements of IPCC. This approach would assist in evaluating the applicability and effectiveness of intra-professional cultural competence in practice, while also exploring gaps in knowledge and understanding of its elements among internationally qualified nurses and locally qualified nurses. Such research would also provide valuable insights into the framework's strengths and limitations, identify practical strategies to enhance its implementation, and offer guidance on how to strengthen the elements of IPCC within nursing regulatory bodies, educational providers and healthcare organisations.

Additionally, as identified in **Study Four** - the interviews with educational and regulatory experts, academics and clinical educators- there may be variability across different providers in how nursing curricula implement content governed by accreditation standards. Future research would be valuable in assessing the nature and extent of the gaps that exist and, if so, the extent of these differences. The findings from such research could provide crucial insights into the content delivered in nursing programs nationwide, helping to identify inconsistencies across providers. These findings could be instrumental in defining a standardised foundational framework for the elements of intra-professional cultural competence, ensuring consistency and equity in content delivery within nursing education.

Study Four also revealed the existence of cultural cliques in clinical settings, often formed by internationally qualified nurses from similar cultural or linguistic backgrounds. Future research would be valuable in exploring the roots, nature and implications of this phenomenon, which remains largely unexamined. The examination of regulatory documents in **Study Three -** the examination of regulatory documents - highlighted that Australian regulatory documents include content addressing the elements of intra-professional cultural competence. Future research could focus on examining this content from a practical perspective, identifying gaps in the application of standards outlined in these documents and their translation into clinical practice.

Additionally, mentorship has been recognised as a valuable tool in nursing across various levels. Future research on the effectiveness of mentorship programs for academics, students and IQNs with CALD backgrounds would be highly beneficial. Such studies could help identify barriers and facilitators, providing a foundation for developing targeted programs aimed at enhancing the elements of IPCC within nursing in the future. Although this is an exploratory

study, and no empirical research has yet been conducted to test the effectiveness of IPCC, the findings may be transferable to other health care professionals in the future.

Finally, this thesis has established the crucial role of nursing managers in preventing and addressing R&D and/or B&H, fostering positive work environments and promoting diversity within healthcare teams. Future studies could investigate potential knowledge and training gaps among nursing managers regarding the elements of IPCC. Such research would be beneficial in evaluating nursing managers' capacity to manage conflicts, enhance diversity, and effectively prevent and address R&D and/or B&H in clinical settings.

Future research could adopt an intersectional lens to explore how these interrelated dynamics unfold across diverse clinical contexts, countries and regulatory environments. Such work would significantly enhance the understanding of the mechanisms that sustain inequity in nursing and support the development of targeted, evidence-based interventions that benefit both IQNs and the broader profession. As the global reliance on internationally qualified nurses (IQNs) has increased in many high-income health systems over the past decade (WHO, 2025; OECD, 2023), new research should move beyond to interrogate how cultural–linguistic demands intersect with pre-existing social and economic inequalities inside healthcare organisations**.** As demonstrated in this thesis, IQNs face a range of challenges in their integration process, influenced by both personal and structural factors (Correa-Betancour et al., 2024). For example, working in a second language extends beyond the clinical setting; it impacts nurses' confidence, professional identity, peer relationships, access to informal learning networks, and ultimately their career progression (Crawford et al., 2016; Dywili et al., 2021; Philip et al., 2019; Zanjani et al., 2021). At the same time, promotion systems, pay structures and task allocation often reproduce racialized or class-based hierarchies that systematically disadvantage migrant and minority nurses (Amis et al., 2020; Iheduru-Anderson, 2020).

In addition, future research could develop work relevant to the transferability of this research to other professional settings in health, such as medicine, allied health and emergency professionals.

7.6 Conclusion

In conclusion, this thesis underscores both the persistent barriers and the existing facilitators influencing the professional integration of internationally qualified nurses, particularly those with culturally and linguistically diverse backgrounds in Australia. It also highlights the potential of the elements of intra- professional cultural competence as a strategic approach to foster a more inclusive and supportive nursing environment. While numerous initiatives at the regulatory, educational, organisational and individual levels demonstrate a commitment to positive change, a collaborative and coordinated effort is still required to overcome entrenched obstacles such as racism, discrimination, bullying and harassment.

Achieving this shift will necessitate not only cooperation among regulators, educators and healthcare organisations, but also a cultural transformation within the nursing profession itself – one that actively promotes respect, equity and inclusion. By implementing and refining the recommendations identified in this research, the Australian healthcare system could strengthen its efforts to cultivate a workplace culture that better values diversity, upholds professional respect and empowers nurses of all backgrounds. Ultimately, an environment guided by the elements of IPCC and underpinned by inclusivity can help ensure high-quality patient care and a more unified, resilient nursing workforce.

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Appendices

Appendix A. Study Four Interview questions

Study Questions: Clinical Educators

Thank you for agreeing to be interviewed today. My PhD is examining intra-professional cultural competence (IPCC) and how it is taught in one undergraduate curriculum and practised in the clinical setting. The questions I will be asking you are all based on the **NMBA Code of Conduct** for Nurses (2018) and the expectations within the Code for IPCC. Please be assured there will be no identifying information of any sort in the reported data, so all information from participants will be anonymous.

I. I would like to begin with some brief demographic data:

1. What are your qualifications?
2. Where and when did you obtain them?
3. How long have you been working as a clinical facilitator?
4. Do you identify yourself as Aboriginal or Torres Strait Islander?
5. Do you have a Culturally and Linguistically Diverse (CALD) background?

II. **I would now like to focus on the *NMBA Code of Conduct for Nurses focusing specifically on* intra-professional cultural competence (IPCC).** Principle 3 in the *NMBA Code of Conduct for Nurses* describes the expectations for cultural practices and respectful relationships.

1. Point 3.2 (b) of the code stated that "To ensure culturally safe and respectful practice nurses must respect diverse cultures, beliefs, gender identities, sexualities and experiences of people, including among team members".

   - Focusing on IPCC: How would you help to strengthen this conduct with your BN students?
   - Have you seen or ever witnessed situations on clinical placement where these practices were not observed?
   - If so, how did you manage that with your students?

2. Point 3.2 (d) says that nurses must: "adopt practices that respect diversity, avoid bias, discrimination and racism, and challenge belief based upon assumption (for example, based on gender, disability, race, ethnicity, religion, sexuality, age or political beliefs)"

   - Focusing on IPCC: How would you help to strengthen this conduct with your BN students?
   - Have you seen or ever witnessed situations on clinical placement where these practices were not observed?
   - If so, how did you manage that with your students?

3. Point 3.2.(f) states that nurses must: "create a positive, culturally safe work environment through role modelling, and supporting the rights, dignity and safety of others, including people and colleagues"

   - Focusing on IPCC: How would you help to strengthen this conduct with your BN students?
   - Have you seen or ever witnessed situations on clinical placement where these practices were not observed? If so, how did you manage that with your students?

4. Point 3.4 of the Code relates to bullying and harassment. This is defined as behaviour involving "repeatedly and intentionally use words or actions against someone or a group of

people". Point 3.4 (a) states that nurses must: never engage in, ignore, or excuse such behaviour".

- Focusing IPCC: Have you witnessed any situation related to the above while you were in the clinical setting with BN students?
- How would you help to develop the positive aspects of this requirement in your BN students?
- Have you seen or ever witnessed situations on clinical placement where these practices were not observed? If so, how did you manage that with your students?

5. Point 3.4. (b) states that nurses must: "recognise that bullying and harassment takes many forms, including behaviours such as physical and verbal abuse, racism, discrimination, violence, aggression, humiliation, pressure in decision-making, exclusion and intimidation directed towards people or colleagues"
   - Have you witnessed any situations where bullying and harassment related to racism or discrimination or any other form that might relate to a lack of IPCC?
   - If so, how did you manage that with your students? How would you help to ensure the positive aspects of this requirement in your BN students?

6. Point 3.4. (c) refers to the role of social media in this type of conduct. It states that nurses must: "understand social media is sometimes used as a mechanism to bully or harass, and that nurses should not engage in, ignore or excuse such behaviour."
   - Are you aware of situations involving BN students where social media has been used for bullying and harassment of fellow students or co-workers in relation to an absence of IPCC?
   - If so, how did you support the students?
   - Have you ever discussed this issue at all on placement?

7. Finally, the last two points of this section of the code state that nurses would "act to eliminate bullying and harassment, in all its forms, in the workplace, and escalate their concerns if an appropriate response does not occur".
   - How might or do you help to strengthen such conduct in your BN students?
   - Have you seen or ever witnessed situations on clinical placement where these practices were not observed and where you believed the issue might have related to a lack of IPCC? If so, how did you manage that with your students?

8. Thank you so much for agreeing to this interview. Is there anything else you would like to comment on today?

Thank you for your time and consideration.

Study Questions: Academics teaching cultural competence

Thank you for agreeing to be interviewed today. My PhD is examining intra-professional cultural competence (IPCC) and how it is taught in the undergraduate curriculum and practised in the clinical setting. The questions I will be asking you are all based on the results of **a systematic review** and expectations within **the ANMAC RN Standards** and the **NMBA Code of Conduct** for IPCC. Please be assured there will be no identifying information of any sort in the reported data, so all information from participants and the School of Nursing will be anonymous.

I. Demographic data:

1. What are your qualifications?
2. Where and when did you obtain them?
3. How long have you been working at this school of nursing?
4. Do you identify yourself as Aboriginal or Torres Strait Islander?
5. Do you have a Culturally and Linguistically Diverse (CALD) background?

II. Now I would like to focus on intra-professional cultural competence.

1. Where and how is intra-professional cultural competence included in the BN curriculum?

We have just completed a systematic review examining barriers and facilitators to the professional integration of Internationally qualified nurses (IQNs) in Australia. The literature says that IQNs face some challenges and issues in regard to their professional integration. Here are some of the most commonly mentioned in Australia:

- Language proficiency and differences in communication patterns
- Cultural differences in the nursing role compared to their role in their country of origin
- Lack of support from colleagues
- Insufficient mentoring from supervisors
- Lack of appreciation from colleagues
- Discrimination and racism (from colleagues, subordinates, patients and visitors) in the form of: accent discrimination, direct confrontation, insubordination from staff, hostile interactions, lack of professional development opportunities, and non-inclusive behaviours. Considering these findings:

2. To what extent do you find these to be issues in your workplace or in the health workplace?

3. Does the BN curriculum include specific content to address all or any of these issues?

4. Is there more that could be done in nurse education to address the following situations?

   a) Differences in intra-professional communication patterns
   b) Cultural differences for IQNs in relation to the Australian nursing role compared to their role in their country of origin
   c) Intra-professional discrimination and racism

III. **I would like to focus now on the ANMAC RN Standards for Practice**. In particular, I would like to focus on Standard 3: Program of Study.

Statement IV says: "The program's content and subject learning outcomes integrate principles of intraprofessional and interprofessional learning and practice".

Statement V of the ANMAC standards says: "The program's content and subject learning outcomes embed principles of diversity, culture, inclusion and cultural safety for all people". In relation to intra-professional cultural competence:

1. Do you think this content is sufficient to address the needs of intra- professional cultural competence?

2. What (if anything) might be done further to embed these statements?

IV. **Now I would like to focus now on the *NMBA Code of Conduct for Nurses*.** Principle 3 in the *NMBA Code of Conduct for Nurses* talks about Cultural practice and respectful relationships. Specifically Point 1 identifies the expectation for culturally safe and respectful practice and Point 3 addresses the problem of bullying and harassment.

1. What is the school's approach to integrate these requirements of the NMBA Code of Conduct into the curriculum?

V. Thank you so much for agreeing to this interview. Is there anything else you would like to comment on today?

Thank you for your time and consideration.

Study Questions: Regulatory and Educational Experts

Thank you for agreeing to be interviewed today. My PhD is to ascertain how and why intra-professional cultural competence is taught and practised in the clinical setting in one undergraduate nursing program in Australia. The questions I will be asking you are all based on the result of a **systematic review**, the **ANMAC RN Standards for Practice**, and the **NMBA Code of Conduct for Nurses**.

Please be assured there will be no identifying information of any sort in the reported data, so all information from participants will be anonymous.

I. I would like to begin with some brief demographic data:

1. What are your qualifications?
2. Where and when did you obtain them?
3. How long have you been at [name of the institution and position][1]?
4. Do you identify yourself as Aboriginal or Torres Strait Islander?
5. Do you have a Culturally and Linguistically Diverse (CALD) background?

II. Now I would like to focus on intra-professional cultural competence.

1. We have just completed a systematic review examining barriers and facilitators to the professional integration of Internationally qualified nurses (IQNs) in Australia. The literature says that IQNs face some challenges and issues with regard to their professional integration. Here are some of the most commonly mentioned in Australia:

- Language proficiency and differences in communication patterns
- Cultural differences in the nursing role compared to their role in their country of origin
- Lack of support from colleagues
- Insufficient mentoring from supervisors
- Lack of appreciation from colleagues
- Discrimination and racism (from colleagues, subordinates, patients and visitors) in the form of accent discrimination, direct confrontation, insubordination from staff, hostile interactions, lack of professional development opportunities, and non-inclusive behaviours. Considering these findings:

2. Where and how is intra-professional cultural competence included in the Australian BN curriculum?

3. To what extent do you find these to be issues in your workplace or in the health workplace?

4. Do you consider that the BN curriculum includes specific content to address all or any of these issues?

[1] This information has been modified to ensure confidentiality.

5. What (if anything) further might need to be done in nurse education to address the following situations?
   a) Differences in intra-professional communication patterns
   b) Cultural differences for IQNs in relation to the Australian nursing role compared to their role in their country of origin
   c) Intra-professional discrimination and racism

III. **I would like to focus now on the ANMAC RN Standards for Practice**. In particular, I would like to focus on Standard 3: Program of Study.

Statement IV says: "The program's content and subject learning outcomes integrate principles of intraprofessional and interprofessional learning and practice".

Statement V of the ANMAC standards says: "The program's content and subject learning outcomes embed principles of diversity, culture, inclusion and cultural safety for all people". In relation to intra-professional cultural competence:

1. Do you think this content is sufficient to address the needs of intra- professional cultural competence?

2. What (if anything) might be done further to embed these statements?

IV. **Now I would like to focus now on the *NMBA Code of Conduct for Nurses*.** Principle 3 in the *NMBA Code of Conduct for Nurses* talks about Cultural practice and respectful relationships.

Specifically Point 3.1 identifies the expectation for culturally safe and respectful practice and Point 3.3 addresses the problems of bullying and harassment. With regards to intra-professional cultural competence"

1. In your opinion, are these aspects of the NMBA Code of Conduct sufficiently highlighted in the undergraduate BN curriculum?

2. Do you think these aspects of the NMBA Code of Conduct are well integrated and respected in the clinical setting?

3. In your opinion, what (if anything) might need to be done further to assure these aspects of the NMBA Code of Conduct is respected in the clinical setting?

Thank you so much for agreeing to this interview. Is there anything else you would like to comment on today?

Thank you for your time and consideration.

Appendix B. Study Four: Participant information statements

Participant Information Statement: Academics and Clinical Educators

Research Study: How and why is intra-professional cultural competence taught and practised in one school of nursing in Australia.

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1. What is this study about?

We are conducting a research study about education for intra-professional cultural competence. The aim of this research is to ascertain how and why intra-professional cultural competence is taught and practised in one school of nursing Australia.

Taking part in this study is voluntary. Please be assured there will be no identifying information of any sort in the reported data, so all information from participants will be anonymous.

Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

2. Who is running the study?

The study is being carried out by the following researchers:

- **Lead Supervisor Professor Stephanie D. Short**, School of Health Science, Faculty of Medicine and Health, The University of Sydney, Sydney, New South Wales, Australia.
- **Supervisor Professor Emerita Mary Chiarella**, Susan Wakil School of Nursing and Midwifery Faculty of Medicine and Health, The University of Sydney, Sydney, New South Wales, Australia.
- **Supervisor Dr Madhan Balasubramanian**, Health Care Management, College of Business, Government and Law, Flinders University, Adelaide, South Australia, Australia & Faculty of

Medicine and Health, Menzies Centre for Health Policy and Economics, School of Public Health, The University of Sydney, Sydney, New South Wales, Australia

- **Marcela Ivonne Correa-Betancour** is conducting this study as the basis for the degree of Doctor of Philosophy at The University of Sydney, Faculty of Medicine and Health. The candidate received support to undertake her PhD from the National Agency of Research Development, Ministry of Science, Technology, Knowledge and Innovation, Government of Chile.

No conflict of interest has been declared by the authors and no financial benefits will arise from the conduct of the research.

3. Who can take part in the study?

You have been invited to take part in this study because you are an academic at the [name of the school of nursing and the university].[1] Your contact details were obtained from the University website.

4. What will the study involve for me?

If you decide to take part in this study, you will be asked to participate in an interview at a mutually agreed safe and private location. This interview will consist of open questions, it will take approximately one hour, and it will be audio-recorded.

5. Can I withdraw once I've started?

- Being in this study is completely voluntary and you do not have to take part.
- Your decision will not affect your current or future relationship with the researchers or anyone else at [name of the school of nursing and the university][2].
- We do not anticipate your decision will affect your relationship with the [name of the school of nursing and the university][1]
- If you decide to take part in the study and then change your mind you can withdraw by sending an email to mcor7043@uni.sydney.edu.au
- If you take part in an interview you may refuse to answer any questions that you do not wish to answer.
- If you choose to withdraw, we will not collect any more information from you. Please let us know at the time you withdraw what you would like us to do with information we have collected about you up to that point.

6. Are there any risks or costs?

Aside from giving up your time, we do not expect that there will be any risks or costs associated with taking part in this study.

---

[2] This information has been modified to ensure confidentiality.

7. Are there any benefits?

You will not receive any direct benefits from being in the study. However, we hope that the results will inform teaching around intra-professional cultural competence (IPCC) for locally qualified nurses (LQNs) at undergraduate level.

8. What will happen to information that is collected?

By providing your consent, you are agreeing to us collecting some demographic information about you for the purposes of this study.

Any information you provide us will be stored securely and we will only disclose identifiable information with your permission unless we are required by law to release information. We are planning for the study findings to be published.

The recorded data will be transcribed to Word. All data will be secured safely using the Research Data Management online storage supported by the University of Sydney and accessed by only the research team. Research data will be stored online on the University of Sydney's Research Data Storage for a period of 5 years and then deleted permanently.

Neither you nor the [name of the school of nursing and the university][1] will be individually identifiable in publications.

9. Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study.

If you are interested in receiving feedback or the study result you can contact Mrs Marcela Correa-Betancour at this email mcor7043@uni.sydney.edu.au. This feedback will be in the form of a brief lay summary.

10. What if I would like further information?

When you have read this information, the following researcher/s will be available to discuss it with you further and answer any questions you may have:

Mrs. Marcela Correa-Betancour
PhD candidate
Email: mcor7043@uni.sydney.edu.au
+61423285877

11. What if I have a complaint or any concerns?

The ethical aspects of this study have been approved by the Human Research Ethics Committee (HREC) of The University of Sydney [2023/471] according to the *National Statement on Ethical Conduct in Human Research (2007).*

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the University:

Human Ethics Manager
human.ethics@sydney.edu.au
+61 2 8627 8176

This information sheet is for you to keep.

Participant Information Statement: Regulatory Experts

Research Study: How and why is intra-professional cultural competence taught and practised in one school of nursing in Australia.

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- **Supervisor Dr Madhan Balasubramanian**, Health Care Management, College of Business, Government and Law, Flinders University, Adelaide, South Australia, Australia & Faculty of

Medicine and Health, Menzies Centre for Health Policy and Economics, School of Public Health, The University of Sydney, Sydney, New South Wales, Australia

- **Marcela Ivonne Correa-Betancour** is conducting this study as the basis for the degree of Doctor of Philosophy at The University of Sydney, Faculty of Medicine and Health. The candidate received support to undertake her PhD from the National Agency of Research Development, Ministry of Science, Technology, Knowledge and Innovation, Government of Chile.

No conflict of interest has been declared by the authors and no financial benefits will arise from the conduct of the research.

3. Who can take part in the study?

You have been invited to take part in this study because you are considered an expert in Nursing for your role at the [name of the institution][3]

Your contact details were obtained from the website of the organisation you are affiliated.

4. What will the study involve for me?

If you decide to take part in this study, you will be asked to participate in an interview at a mutually agreed safe and private location. This interview will consist of open questions, it will take approximately one hour, and it will be audio-recorded.

5. Can I withdraw once I've started?

- Being in this study is completely voluntary and you do not have to take part.
- Your decision will not affect your current or future relationship with the researchers or anyone else at The University of Sydney.
- We do not anticipate your decision will affect your relationship with the [name of the university][2]
- If you decide to take part in the study and then change your mind you can withdraw by sending an email to mcor7043@uni.sydney.edu.au
- If you take part in an interview you may refuse to answer any questions that you do not wish to answer.
- If you choose to withdraw, we will not collect any more information from you. Please let us know at the time you withdraw what you would like us to do with information we have collected about you up to that point.

6. Are there any risks or costs?

Aside from giving up your time, we do not expect that there will be any risks or costs associated with taking part in this study.

---

[3] This information has been modified to ensure confidentiality.

7. Are there any benefits?

You will not receive any direct benefits from being in the study. However, we hope that the results will inform teaching around intra-professional cultural competence (IPCC) for locally qualified nurses (LQNs) at undergraduate level.

8. What will happen to information that is collected?

By providing your consent, you are agreeing to us collecting some demographic information about you for the purposes of this study.

Any information you provide us will be stored securely and we will only disclose identifiable information with your permission unless we are required by law to release information. We are planning for the study findings to be published.

The recorded data will be transcribed to Word. All data will be secured safely using the Research Data Management online storage supported by the University of Sydney and accessed by only the research team. Research data will be stored online on the University of Sydney's Research Data Storage for a period of 5 years and then deleted permanently. You will not be individually identifiable in publications but will be referred to as a regulatory expert.

9. Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study.

If you are interested in receiving feedback or the study result you can contact Mrs Marcela Correa-Betancour at this email mcor7043@uni.sydney.edu.au. This feedback will be in the form of a brief lay summary.

10. What if I would like further information?

When you have read this information, the following researcher/s will be available to discuss it with you further and answer any questions you may have:

Mrs. Marcela Correa-Betancour

PhD candidate
Email: mcor7043@uni.sydney.edu.au
+61423285877

11. What if I have a complaint or any concerns?

The ethical aspects of this study have been approved by the Human Research Ethics Committee (HREC) of The University of Sydney [2023/471] according to the *National Statement on Ethical Conduct in Human Research (2007).*

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact the University:

Human Ethics Manager
human.ethics@sydney.edu.au
+61 2 8627 8176

This information sheet is for you to keep.

Appendix C. Study Four: Participant consent forms

Participant Consent Form: Academics and CEs

Research Study: How and why is intra-professional cultural competence taught and practised in one school of nursing in Australia.

Professor Stephanie D. Short
School of Health Science
Faculty of Medicine and Health
The University of Sydney
Sydney, New South Wales, Australia
Phone: +61 407580286
Email: stephanie.short@sydney.edu.au

Mrs. Marcela Correa-Betancour
PhD student
School of Health Science
Faculty of Medicine and Health
Email: mcor7043@uni.sydney.edu.au

Participant Name _____

I agree to take part in this research study. In giving my consent, I confirm that that:

- The details of my involvement have been explained to me, and I have been provided with a written Participant Information Statement to keep.
- I understand the purpose of the study is to investigate intra-professional cultural competence contents in a nursing program.
- I acknowledge that the risks and benefits of participating in this study have been explained to me to my satisfaction.
- I understand that in this study I will be required to give a face-to-face interview.
- I understand that my participation may be audio recorded for transcription and data analysis purposes, and there will be no identifying information of any sort in the reported data, so all information from participants will be anonymous.
- I understand that being in this study is completely voluntary.
- I am assured that my decision to participate will not have any impact on my relationship with the research team or the [name of the school of nursing and the university][4]

[4] This information has been modified to ensure confidentiality.

- I understand that I am free to withdraw from this study at any time and that I can choose to withdraw any information I have already provided (unless the data has already been de-identified or published).
- I have been informed that the confidentiality of the information I provide will be protected and will only be used for purposes that I have agreed to. I understand that information identifying me will only be told to others with my permission, except as required by law.
- I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.
- I confirm the following:

I consent to recordings (audio)	Yes ☐	No ☐
I would like to review my interview transcripts	Yes ☐	No ☐
I would like feedback on the overall results of this study	Yes ☐	No ☐

If you answered **yes**, please provide your preferred contact details (email/telephone/postal address):

_____

- I understand that after I sign and return this consent form it will be retained by the researcher, and that I may request a copy at any time.

Participant Name _____

Signature _____

Date _____

Participant Consent Form: Regulatory Experts

Research Study

How and why is intra-professional cultural competence taught and practised in one school of nursing in Australia

Professor Stephanie D. Short
School of Health Science
Faculty of Medicine and Health
The University of Sydney
Sydney, New South Wales, Australia
Phone: +61 407580286
Email: stephanie.short@sydney.edu.au

Mrs. Marcela Correa-Betancour
PhD student
School of Health Science
Faculty of Medicine and Health
Email: mcor7043@uni.sydney.edu.au

Participant Name _____

I agree to take part in this research study. In giving my consent, I confirm that that:

- The details of my involvement have been explained to me, and I have been provided with a written Participant Information Statement to keep.
- I understand the purpose of the study is to investigate intra-professional cultural competence contents in a nursing program.
- I acknowledge that the risks and benefits of participating in this study have been explained to me to my satisfaction.
- I understand that in this study I will be required to give a face-to-face interview.
- I understand that my participation may be audio recorded for transcription and data analysis purposes, and there will be no identifying information of any sort in the reported data, so all information from participants will be anonymous.
- I understand that being in this study is completely voluntary.

- I am assured that my decision to participate will not have any impact on my relationship with the research team or the [name of the school of nursing and the university][5]
- I understand that I am free to withdraw from this study at any time and that I can choose to withdraw any information I have already provided (unless the data has already been de-identified or published).
- I have been informed that the confidentiality of the information I provide will be protected and will only be used for purposes that I have agreed to. I understand that information identifying me will only be told to others with my permission, except as required by law.
- I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.
- I confirm the following:

I consent to recordings (audio)	Yes ☐	No ☐
I would like to review my interview transcripts	Yes ☐	No ☐
I would like feedback on the overall results of this study	Yes ☐	No ☐

If you answered **yes**, please provide your preferred contact details (email/telephone/postal address):

_____

- I understand that after I sign and return this consent form it will be retained by the researcher, and that I may request a copy at any time.

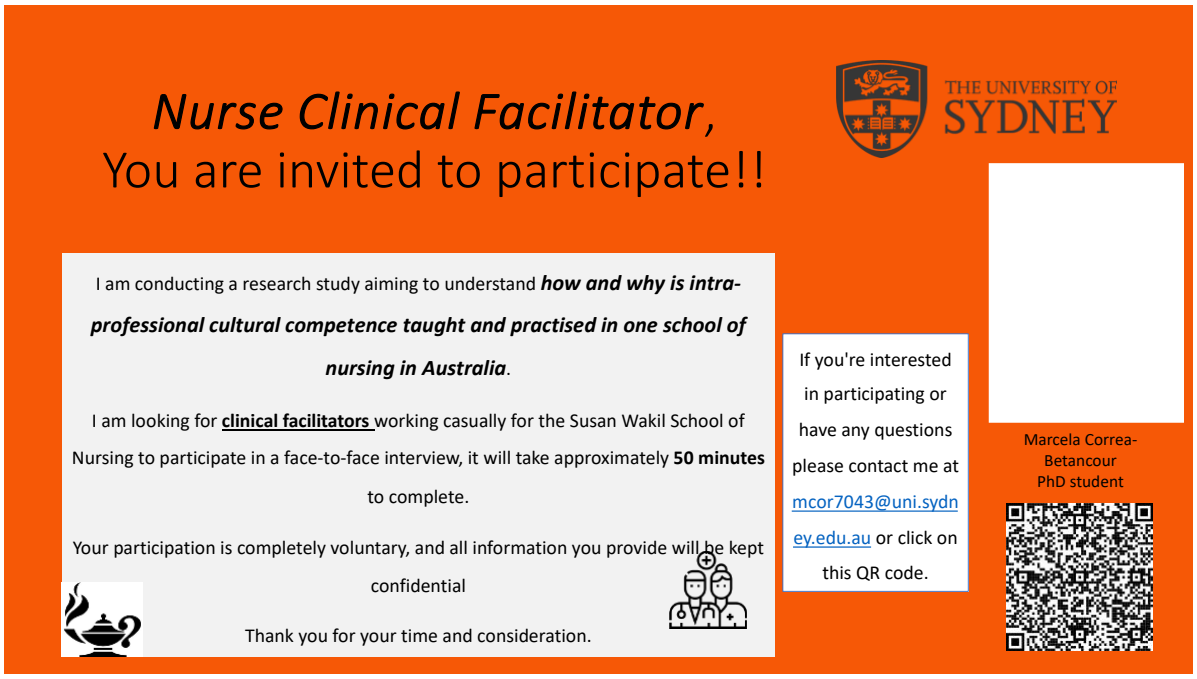
Participant Name _____

Signature _____

Date _____

[5] This information has been modified to ensure confidentiality.

Appendix D. Study Four: Flyer sent to clinical educators



Appendix E. Study Four: Ethics approval

THE UNIVERSITY OF SYDNEY

Research Integrity & Ethics Administration
Human Research Ethics Committee

Monday, 7 August 2023

Prof Stephanie Short
Health Systems and Global Populations; Faculty of Medicine and Health
Email: stephanie.short@sydney.edu.au

Dear Stephanie,

The University of Sydney Human Research Ethics Committee (HREC) has considered your application.

After consideration of your response to the comments raised your project has been approved.

Approval is granted for a period of four years from **11/07/2023** to **11/07/2027.**

Project No.: **2023/471**

Project Title: **How and why is intra-professional cultural competence taught and practised in one school of nursing in Australia.**

Authorised Personnel: **Short Stephanie; Chiarella Mary; Balasubramanian Madhan; Correa-Betancour Marcela;**

First Annual Report due: **11/07/2024**

Documents Approved:

Date Uploaded	Version number	Document Name
26/07/2023	version 2	version 2 email to teaching staff
26/07/2023	version 2	version 2 letters for regulatory experts
26/07/2023	version 2	version 2 questions for content teaching staff
26/07/2023	version 2	version 2 questions for clinical facilitators
26/07/2023	version 2	V2 Study questions regulatory or educational experts x 3
26/07/2023	version 2	version 2 flyer
26/07/2023		Research protocol
26/05/2023		Participant Consent Forms x 5
26/05/2023		Participant information statements x 5 -teaching staff clini

For Noting

- Please include a version number and date in the footer of all public-facing documents and revise these each time changes are made to the documents. This allows identification of original, updated, and approved versions and to assist the committee in any future modification requests.

Condition/s of Approval

- Research must be conducted according to the approved proposal.
- An annual progress report must be submitted to the Ethics Office on or before the anniversary of approval and on completion of the project.

Research Integrity & Ethics Administration
Level 2, Margaret Telfer Building (K07)
The University of Sydney
NSW 2006 Australia

T +61 2 9036 9161
E human.ethics@sydney.edu.au
W sydney.edu.au/ethics

ABN 15 211 513 464
CRICOS 00026A

- You must report as soon as practicable anything that might warrant review of ethical approval of the project including:
  - Serious or unexpected adverse events (which should be reported within 72 hours).
  - Unforeseen events that might affect continued ethical acceptability of the project.
- Any changes to the proposal must be approved prior to their implementation (except where an amendment is undertaken to eliminate *immediate* risk to participants).
- Personnel working on this project must be sufficiently qualified by education, training and experience for their role, or adequately supervised. Changes to personnel must be reported and approved.
- Personnel must disclose any actual or potential conflicts of interest, including any financial or other interest or affiliation, as relevant to this project.
- Data and primary materials must be retained and stored in accordance with the relevant legislation and University guidelines.
- Ethics approval is dependent upon ongoing compliance of the research with the *National Statement on Ethical Conduct in Human Research*, the *Australian Code for the Responsible Conduct of Research*, applicable legal requirements, and with University policies, procedures and governance requirements.
- The Ethics Office may conduct audits on approved projects.
- The Chief Investigator has ultimate responsibility for the conduct of the research and is responsible for ensuring all others involved will conduct the research in accordance with the above.
- The Clinical Trials Support Office has been notified as outlined in the University's Clinical Trials Policy where a clinical trial is being undertaken.

This letter constitutes ethical approval only.

Please contact the Ethics Office should you require further information or clarification.

Associate Professor Stephen Fuller
Chair
Human Research Ethics Committee (HREC 2)

The University of Sydney HRECs are constituted and operate in accordance with the National Health and Medical Research Council's (NHMRC) current National Statement on Ethical Conduct in Human Research (2018) and the NHMRC's current Australian Code for the Responsible Conduct of Research (2018).