STRENGTHENING THE NURSES AND HEALTH CARE PROFESSIONALS' CAPACITY TO DELIVER CULTURALLY COMPETENT AND COMPASSIONATE CARE

Learning Unit 1:

Stop bullying at healthcare work environment. Promotion of a compassionate and culturally competent leadership as a protective factor

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THEORETICAL COMPONENT

This section is part of the self-directed learning and should therefore be read before the classroom session.

➢ Relevant principles and values for the tool

- Compassion
- Respect
- Responsibility
- Competence
- Equality
- Understanding
- Trust
- Kindness
- Guidance
- Experience
- Empathy
- Sensitivity
- Confidentiality
- Supportive

All nurses have two main rights: a) a workplace that is fair and equitable; and b) to be treated with respect and dignity during the course of their daily work.

➢ Aim of the tool

The aim of this tool is to mentor seniors, managers and leaders at healthcare to identify cases of bullying at their workplace, as well as to promote a positive work environment encouraging healthy communication and interaction.

➢ Learning outcomes

Leaders should be able to:

- Be aware about the relevance of equity, respect, kindness and dignity for a positive work environment.
- Identify negative behaviours (in themselves and their team) that can entail bullying cases.
- Improve quality in their interaction and communication with their teams.
- Organize and manage more efficiently and equally the working environment, tasks and functions.
- Promote healthy and positive values within their teams.

➢ Relevant definitions and terms

a) Compassion

Compassion seems to be a universal concept there are likely to be aspects of it that are culturally specific, and therefore definitions of compassion may vary between different cultures. However, compassion can be defined as **understanding** or **being aware** of another person's **suffering** and **acting** to end this suffering (Schantz, 2007).

b) Culturally competent compassion

According to Papadopoulos (2011), culturally competent compassion is <<*the human quality of* ***understanding the suffering*** *of others and wanting to* ***do something*** *about it using culturally appropriate and acceptable nursing/healthcare interventions which take into consideration both the patients and the carers* ***cultural backgrounds*** *as well as the* ***context*** *in which care is given*>>. This video summarizes the Papadopoulos Model of Culturally Competent and Compassion: https://www.youtube.com/watch?v=zjKzO94TevA

c) Culturally competent and compassionate health care leadership

According to the results of the IENE4 Output 4 culturally competent and compassionate health care leadership is defined as <<*the process that a leader goes through in demonstrating* ***culturally aware***, ***knowledgeable***, ***sensitive***, ***competent*** *and* ***compassionate standards*** *of leadership and care. S/he adopts and applies* ***leading principles*** *and values, leadership* ***moral virtues***, ***inspires*** *others with his/her example and vision; provides* ***quality***, *appropriate and* ***equal*** *health care, becomes a* ***role model*** *and acts within a culturally competent and compassionate working environment that s/he helps to develop and nurture*>>.

d) Workplace bullying

Based on the review carried out by Cleary et al. (2010) bullying is a **repeated verbal and/or physical behavioural activity at workplace** (but not only confined to this setting) considered humiliating, intimidating, threatening or demeaning addressed to a person or various individuals aimed to harm him/her or them. The perpetrator/s and victim/s know each other, and can occur between staff at the same level or between different hierarchical levels. These behaviours usually **escalate in severity over time** and may emerge from the nature of the work organization.

Most **common bullying behaviours** among nurses and other healthcare professionals are (Johnson & Rea, 2009; Simons, 2008):

- Being allocated an unmanageable workload.
- Being ignored or excluded.
- Having rumours spread about the victim.
- Being ordered to carry out work below victim's competence level.
- Having victim's professional opinion ignored.
- Having information relevant to victim's work withheld.
- Being given impossible targets or deadlines.
- Being humiliated or ridiculed about victim's work.

Employees can be bullied by peers, leaders and even organization's policies and procedures. Thus, <<*bullying is an organizational process arising from a group culture with a self-perpetuating*>> (Hutchinson et al., 2009).

➢ What the research says on the topic

a) Consequences of bullying

Bullying impacts negatively on **victims' physical and psychological health and wellbeing**, as well as on patient safety (Johnson, 2009). Some general psychological effects are the following: headaches, stress, irritability, anxiety, sleep disturbance, excessive worry, impaired social skills, depression, fatigue, loss of concentration, helplessness, psychosomatic complaints and post-traumatic stress disorder (Cleary et al., 2010).

Bullied professionals are more likely to leave their place of employment or have higher rates of absenteeism. This may mean decreased productivity and morale and job satisfaction, which at the end undermine the workplace culture and reputation (Cleary et al., 2010).

b) Conducive factors and causes of bullying cases

The environment and organization where bullying occurs plays a crucial role in enabling, motivating ad triggering bullying. Some related factors are the following (Johnson, 2009):

- **Organizational features**, as changes introducing new procedures or issues and pressures to be more cost-effective and productive, can contribute to a work climate due to high levels of stress, role-conflict and role-ambiguity.
- There are especially two **leadership styles** that favour bullying cases: highly authoritarian and *laissez-faire*. In this sense, some leaders adopt bullying tactics as part of their repertoire of methods to get their employees to work harder or even they use legitimate organizational policies and management practices in an abusive manner.
- Bullying can be **perpetuated** as it is a behaviour that nurses **learn from each other**. So, sometimes new nurses are socialized into the culture of bullying as students and new hires.

c) **Workplace bullying against overseas nurses** (based on Alexis et al., 2007; Allan et al., 2009)

Several studies exploring the experiences of overseas nurses have revealed that in many occasions they experience **lack of support and problems of adjustment** to the new environment. In many cases **racism** was not overtly explicit, but it was inherent to the structure and culture of the health organization, as negative stereotypes or organizational hierarchies.

These situations may be bullying cases aggravated by racism (or **racist bullying**). These professionals suffer: devaluation of their skills and experience through a stigmatizing process; lack of trust by their managers; lack of opportunities for job career promotion and advancement; abusive power relationships by the manager; social exclusion; criticism without any constructive purpose; even, public humiliation and intimidation.

This **devaluation as professional and individual** causes a negative self-perception, low self-steem and loss of self-confidence; aggravated by their frequent vulnerability because their social isolation.

➢ What legal/normative frameworks or conventions says on the topic

At the European level, we find legal framework relating to protect workers from negative situations as bullying at workplace. Some examples are:

- Article 19 of the **European Charter on Social Fundamental Rights of Workers**, stating: <<*Every worker must enjoy satisfactory health and safety conditions in his working environment*>>[1].
- Article 31 of the **European Charter on Fundamental Rights**: <<*Every worker has the right to working conditions which respect his or her health, safety and dignity*>>[2].

In 1993 Sweden was the first country implementing **specific legislation outlawing bullying at work**[3]: <<*recurrent reprehensible or distinctly negative actions which are directed against individual employees in an offensive manner and can result in those employees being placed outside the workplace community*>>.

In Spain we can highlight a guide developed by one of the main national trade unions focused on the **prevention of psychosocial risks at healthcare sector**, specifically at primary care. It provides information about different types of bullying or mobbing, as well as preventive measures and for detection[4].

[1] Community Charter of the Fundamental Social Rights of Workers. 1989, 9th December.

[2] Charter of Fundamental Rights of the European Union. 2000/C 364/01.

[3] Ordinance of the Swedish National Board of Occupational Safety and Health containing Provisions on measures against Victimization at Work AFS 1993:17.

[4] Guía de Prevención de Riesgos Psicosociales en el Sector Sanidad: Atención Primaria. UGT. Madrid, 2007

PRACTICAL COMPONENT OF THE TOOL

A) Self-directed activities (3-5 hours)

Participants will need to spend around 3-5 hours in self-directed learning prior attending the face-to-face session. It is important that to have an understanding of key concepts.

Activity 1: Knowledge

a) Read the definitions and the rest of the key information provided in the Theoretical Part of the tool. Moreover, you can watch the following video which contains a brief overview of the components of culturally competent compassion: https://www.youtube.com/watch?v=zjKzO94TevA. If you have doubts or questions, do not hesitate to take note of them and bring with you to the face-to-face session in order to discuss and clarify them.

b) In the Annex I you will find a figure in which you can include keywords what culturally competent compassion means to you.

Activity 2: Awareness

Negative behaviours and attitudes are too often unchallenged, unrecognized and normalized. So, there is a need to examine which characteristics of the workplace culture may favour bullying attitudes. For this purpose, you are asked to complete a Thought Record (see Annex II) fulfilling the following issues that can foster bullying or discriminatory situations in general or specifically to overseas employees:

a) Values and norms of the working environment.
b) Own behaviours, attitudes or values.
c) Behaviours and attitudes that their teams, peers or leaders do.

You can spend some minutes for this activity every day for a week. After completion, please, bring with you your records to the face-to-face session in order we can compare it and discuss about.

Activity 3: Knowledge, Sensitivity and Competence

Read the paper entitled "*Facilitators and barriers to adjustment of international nurses: an integrative review*" (Kawi & Xu, 2009) included at Annex III to know more about the situations that international nurses find in foreign healthcare environments. Through this reading you will be able to:

- know more about the situations overseas employees live when moving to another country;
- better understand them;
- put into practice this knowledge.

B) Classroom activities (5 hours)

Participants will need to attend a face-to-face session training. The classroom activities will have around 5 h duration and will be guided by the following schedule:

Task	Estimated duration
Registration, welcome and presentation	30 min
Main presentation of relevant definition and concepts	1 hour
Discussion about the detection of cases of bullying	30 min
Presentation about equality and cultural diversity at healthcare workplace	30 min
Coffee break	*20 min*
Case studies	1 hour
Draw a workplan for role modelling	45 min
Close of the session and instructions for the post-classroom activities	15 min

Activity 1: Knowledge

Presentation, definition and clarification of relevant concepts. It will be room for discussion where you can expose your point of view and the definitions you previously worked at home before and after reading the provided materials.

Activity 2: Awareness and sensitivity

The objective of this activity is encouraging the reflection and open discussion about awareness and sensitivity in the detection of cases of bullying at learners' work contexts. For this purpose, the trainer will launch some open questions to facilitate the discussion and exchange of opinions. The proposed points are the following (however, it may be possible to include more according to the learners' interests):

- Do you consider there are many bullying cases at the healthcare sector?
- Do you think we are enough aware about the attitudes and behaviours that favour bullying?
- Do you think the lack of empathy and compassion towards other cultures favour negative attitudes and behaviours against overseas nurses?
- Is the lack of compassion one the main gaps at organizational/managerial level?
- etc.

Activity 3: Knowledge and sensitivity

The trainer will expose a summary of the paper entitled "*Managing equality and cultural diversity in the health workforce*" (Hunt, 2007) in which it is presented practical strategies to managers for supporting overseas nurses. The content will be discussed (maximum participation is requested from learners) through these open questions (for example):

- Does staff from other cultures has more difficulties to carry out their work in an environment that respects them as professionals?
- Which are those barriers?
- How can our organization and ourselves promote inclusion and respect to overseas professionals?

Activity 4: Awareness and sensitivity

Sometimes, people are not aware that their own attitudes and behaviours have an impact on the emotions, perceptions, expectations, satisfaction or efficiency at workplace of their peers or teams. Thus, this activity presents a case discussion activity with short cases (see Annex IV) that may occur at workplace. Learners will be divided in two or three groups and will read and discuss each case.

Activity 5: Competence

Work on your own to draw an action plan following the Annex V to be carried out in your own work context.

C) Role modelling activities (5 hours)

Role modelling and coaching are effective methods to improve and increase the acquisition of nursing leadership skills[5]. So, the activities proposed in this section will be done in participants' working contexts.

Awareness and Competence

- In participants' working place it will be implemented the action plan drawn during the face-to-face session in which it was described the best approach for each of the situations described in.

D) Reflection (3-5 hours)

Please, write a summary of your experience after carrying out the different activities of the module about the awareness, sensitivity, knowledge and competence gained in relation to culturally competent and compassionate leadership (see Annex VII)

[5] "*Literature review on role modelling and coaching in the workplace*". Report developed under the IENE4 project by Azienda Ospedaliera Universitaria Senese (2015).

Assessment

- For the **self-directed learning** → Concept maps.
- For **classroom learning** → Participation in discussions, case studies and the preparation of an action plan for role modelling.
- For **role modelling practice** → A reflection about the awareness, sensitivity, knowledge and competence gained in relation to culturally competent and compassionate leadership.

Evaluation

You will be kindly requested to complete a brief questionnaire to collect your opinion about this learning unit (see Annex VII).

References and useful resources

Alexis, O., Vydelingum, V. & Robbins, I. (2007). Engaging with a new reality: experiences of overseas minority ethnic nurses in the NHS. *Journal of Clinical Nursing, 16*(12): 2221-2228.

Allan, H.T., Cowie, H. & Smith, P. (2009). Overseas nurses' experiences of discrimination: a case of racist bullying? *Journal of Nursing Management, 17*: 898-906.

Cleary, M., Hunt, G.E. & Horsfall, J. (2010). Identifying and Addressing Bullying in Nursing. *Issues in Mental Health Nursing, 31*(5): 331-335.

Hunt, B. (2007). Managing equality and cultural diversity in the health workforce. *Journal of Clinical Nursing, 16*: 2252-2259.

Hutchinson, M., Vickers, M.H., Wilkes, L., & Jackson, D. (2009). "The worse you behave, the more you seem, to be rewarded": Bullying in nursing as organizational corruption. *Employee Responsibilities and Rights Journal, 21*: 213-229.

IENE4 project (2015). *O4: European Model for the development of role models to promote and support culturally competent and compassionate care*. Available at: http://www.ieneproject.eu/download/Outputs/IENE4%20%20European%20Model.pdf

Johnson, S.L. (2009). International perspectives on workplace bullying among nurses: a review. *International Nursing Review, 56*: 34-40.

Johnson, S.L. & Rea, R.E. (2009). Workplace bullying: Concerns for nurse leaders. *Journal of Nursing Administration, 39*: 84-90.

Kawi, J. & Cu, Y. (2009). Facilitators and barriers to adjustment of international nurses: an integrative review. *International Nursing Review, 56*: 174-183.

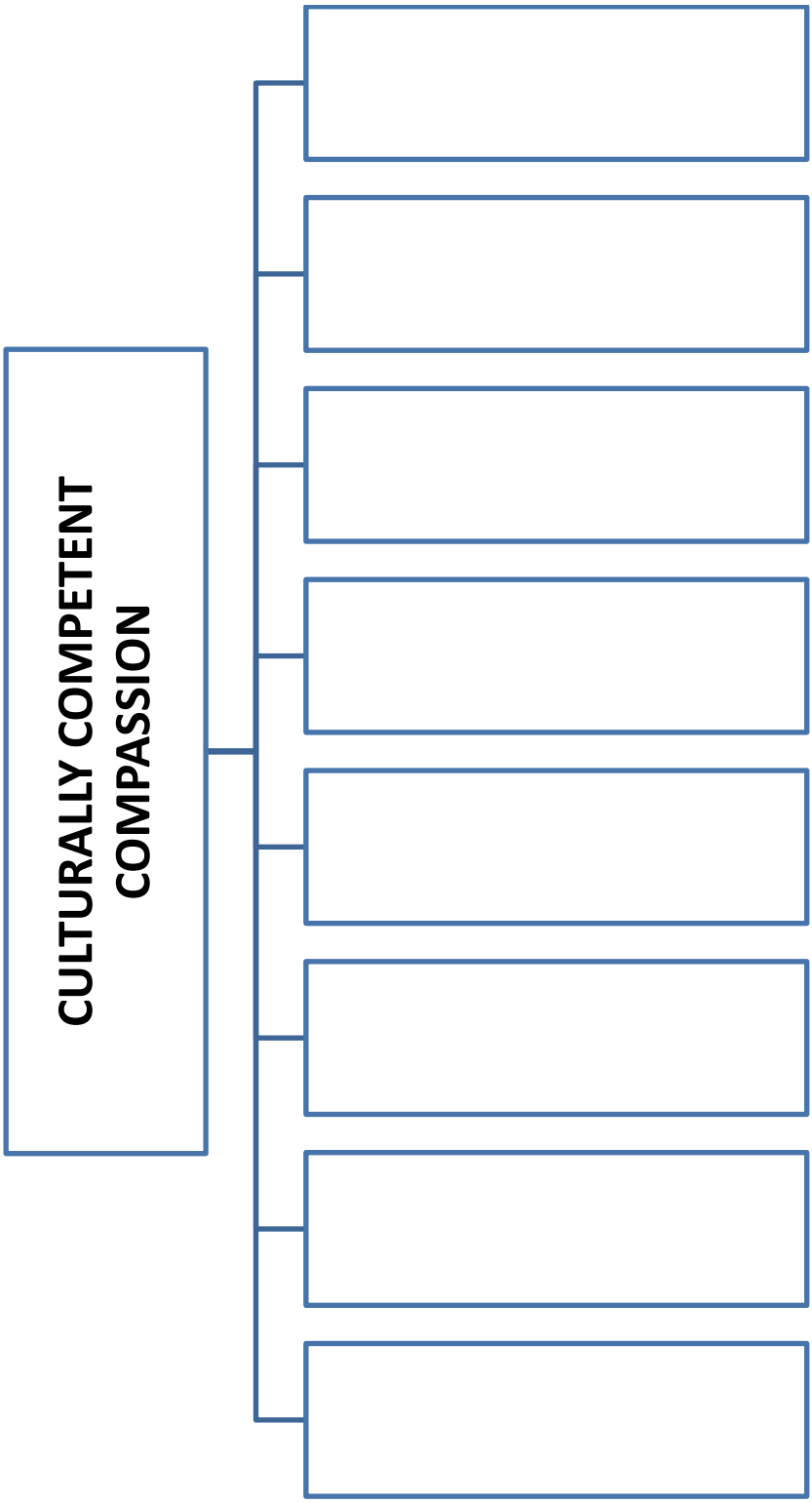
Papadopoulos I. (2011). *Courage, compassion and cultural competence*. The 13th anna reynvaan lecture. Netherlands: De Stadsschouwburg - Amsterdam City Theatre.

Schantz, M.L. (2007). Compassion: a concept analysis. *Nurs. Forum, 42*: 48–55

Simons, S. (2008). Workplace bullying experienced by Massachusetts registered nurses and the relationship to intention to leave the organization. *Advances in Nursing Science, 31*: E48–E59.

ANNEX I. CONCEPTUAL MAP

After reading the materials of the self-directed part of the course, c complete this figure with keywords regarding what culturally competent compassion means to you. Add more spaces if necessary.



ANNEX II – THOUGHTS RECORD

- **Values and norms of the working environment**

Situation *Briefly describe situations based on values and norms of your organization that led to unpleasant feelings*	**Impact on you** *How does this situation impact on you (feelings, emotions, behaviours, etc.)?*	**Impact on others** *How does this situation impact on others (feelings, emotions, behaviours, etc.)?*	**Alternative approach** *You, as a leader, can you do something to change or improve this situation? Describe a new approach and try to put it into action*	**Impact of alternative approach on you** *After putting in action this new approach; how do you feel? Do you behave differently with your team/peers?*	**Impact of alternative approach on you** *After putting in action this new approach; how do others feel? Do they behave differently with you or with others?*	**Improvement** *Have you notice an improvement? This step reinforces the idea that if you change your approach, you will feel more professionally competent and this will also impact on your team/peers*

ANNEX II – THOUGHTS RECORD

- **Own behaviours, attitudes or values**

Situation *Briefly describe situations your leadership style or behavioural approach that led to unpleasant feelings*	**Impact on you** *How does this situation impact on you (feelings, emotions, behaviours, etc.)?*	**Impact on others** *How does this situation impact on others (feelings, emotions, behaviours, etc.)?*	**Alternative approach** *Can you do something to change or improve this situation? Describe a new approach and try to put it into action*	**Impact of alternative approach on you** *After putting in action this new approach; how do you feel? Do you behave differently with your team/peers?*	**Impact of alternative approach on you** *After putting in action this new approach; how do others feel? Do they behave differently with you or with others?*	**Improvement** *Have you notice an improvement? This step reinforces the idea that if you change your approach, you will feel more professionally competent and this will also impact on your team/peers*

ANNEX II – THOUGHTS RECORD

- **Behaviours and attitudes that their teams, peers or leaders do**

Situation *Briefly describe behaviours and/or attitudes of your teams, peers or leaders that led to unpleasant feelings*	**Impact on you** *How does this situation impact on you (feelings, emotions, behaviours, etc.)?*	**Impact on others** *How does this situation impact on others (feelings, emotions, behaviours, etc.)?*	**Alternative approach** *Can you do something to change or improve this situation? Describe a new approach and try to put it into action*	**Impact of alternative approach on you** *After putting in action this new approach; how do you feel? Do you behave differently with your team/peers?*	**Impact of alternative approach on you** *After putting in action this new approach; how do others feel? Do they behave differently with you or with others?*	**Improvement** *Have you notice an improvement? This step reinforces the idea that if you change your approach, you will feel more professionally competent and this will also impact on your team/peers*

Review Article

Facilitators and barriers to adjustment of international nurses: an integrative review

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KAWI J. & XU Y. (2009) Facilitators and barriers to adjustment of international nurses: an integrative review. *International Nursing Review* **56**, 174–183

Background: There is a scarcity of research focusing on issues encountered by international nurses (INs) in their adjustment to foreign health-care environments. Increasingly, INs are relied upon to address staffing shortages in many Western countries. As such, it is vital to identify what facilitates and what the barriers are to the successful adjustment in order to assist their integration into new workplace environments.

Aim: This integrative review identifies facilitators and barriers encountered by INs as they adjust to foreign health-care environments.

Method: Based on Cooper's Five Stages of Integrative Research Review, a systematic search of eight electronic databases was conducted, combined with hand and ancestral searches. Two authors independently reviewed each qualified study for relevance and significance. Subsequently, facilitators and barriers were identified and categorized into themes and subthemes.

Findings: Twenty-nine studies conducted in Australia, Canada, Iceland, UK and the USA were included in this review. Findings indicated that positive work ethic, persistence, psychosocial and logistical support, learning to be assertive and continuous learning facilitated the adjustment of INs to their new workplace environments. In contrast, language and communication difficulties, differences in culture-based lifeways, lack of support, inadequate orientation, differences in nursing practice and inequality were barriers.

Conclusion: The review findings provide the basis for the development and testing of an evidence-informed programme to facilitate the successful adjustment of INs to their new work environments.

Keywords: Adjustment, Barriers, Facilitators, Integrative Review, International Nurses

Introduction

Global migration of nurses has been ongoing for decades (Kingma 2006). The gap between demand and supply has sustained the worldwide migration of nurses to relieve chronic nurse shortages (Aiken et al. 2004; Buchan & Calman 2004; Kingma 2006). International nurses (INs), defined as foreign-trained and/or foreign-born, or recruited nurses from overseas, constitute a significant proportion of the nursing workforce in many Western countries. For example, INs made up 12–15.2% of nurses in the United States of America (USA) (Aiken et al. 2004; Polsky et al. 2007). Similarly in the United Kingdom (UK), about 8% of nurses came from other countries. In 2001–2002, there were reported to be more INs than UK nurses added to the nursing registry (Buchan 2003). The dependence on INs in Canada and Australia demonstrated a similar trend. A 2005 statistics suggested that INs comprised 34.1% of new registered nurses in Ontario, Canada (Baumann et al. 2006), while 23.6% of the Australian nurse workforce was INs (Omeri & Atkins 2002).

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International Nursing Review

While INs have supplemented Western workforces, their adjustment into new work environments frequently posed unique, multidimensional challenges (Xu 2007). Evidence suggests that inadequate transitional programmes were related to undesirable outcomes, including compromised patient care (Zizzo & Xu 2009). What facilitates INs' adjustment to their new work environments? Further, what barriers do INs experience as they adjust? Conceptually, Pilette's (1989) model of adjustment provides a framework for this review study. However, Pilette's model only covers the first 12 months of employment. Based on the literature (Xu 2007; Yi 1993), this period is more accurately termed transition or the acute phase of adjustment because adjustment is usually longer for INs. Therefore, for the purpose of this paper, adjustment is operationally defined as the period of time needed for INs to become comfortable with their new jobs, which may take more than a year after hire. In essence, adjustment involves adaptation to personal, professional, social, cultural and organizational experiences in new environments.

Review studies on international nurses

Four review studies were retrieved from a growing body of research examining the experiences of INs, including facilitators and barriers of adjustment. Alexis & Vydelingum (2005a) examined black and minority INs in the UK. Likupe (2006) analysed African nurses' experiences in the UK. Konno (2006) focused on the adjustment of INs to Australian nursing practice. Lastly, a metasynthesis identified the facets of lived experiences of immigrant Asian nurses working in Western countries (Xu 2007). While providing background information on the adjustment of INs in foreign health-care environments, these reviews focused primarily on given group(s) of INs or specific geographical locations. Studies with an international scope focusing on the facilitators and barriers to the adjustment of INs as one collective group are lacking.

Aim

This integrative review synthesizes what is known about the specific facilitators and barriers when INs adjust to foreign health-care environments.

Method

Cooper's (1989) Five Stages of Integrative Research Review guided this study. According to Cooper: 'Integrative reviews summarize past research by drawing overall conclusions from many separate studies that are believed to address related or identical hypotheses' (p. 13).

Search strategies

The online databases searched up to September 2007 included Cumulative Index to Nursing and Allied Health Literature, Medline, ProQuest Dissertations and Theses, PsychINFO, Sociological Abstracts, Education Resources Information Center, Scopus and Academic Search Premier. Search words used were 'foreign-trained nurses,' 'foreign-born nurses,' 'overseas nurses,' 'internationally recruited nurses,' 'internationally educated nurses,' 'adjustment,' 'integration,' 'adaptation,' 'transition' and their combinations. Five additional studies were included via personal referrals. Additionally, hand searches of selected journals regularly publishing studies on INs (i.e. *Journal of Transcultural Nursing*, *Journal of Nursing Scholarship*) and ancestry searches tracking references in obtained studies were carried out.

Inclusion criterion

Empirical studies published in English describing adjustment issues of INs were included. Dissertations and theses were also included. Non-research articles and demographic studies were excluded. This review focused on INs as defined at the beginning of this paper because they were the focus of most included studies, rather than those voluntarily leaving their home countries.

Cooper's procedures for integrative review

It is necessary to follow systematic guidelines in the appraisal of research studies to ensure a rigorous review and validity of outcomes (Cooper 1989). There are five stages in Cooper's procedures for an integrative review. The first stage is **problem formulation**. For this review, the focus was facilitators and barriers to INs' adjustment into foreign health-care environments. The second stage is **data collection**. Primary studies were retrieved using the aforementioned sources. The third stage is **data evaluation**. The two authors independently reviewed the findings from each qualified study for relevance and significance. Specifically, all identified facilitators and barriers were extricated and tabulated. Findings were subsequently compared and discussed, with discrepancies resolved through consensus. The fourth stage is **data analysis and interpretation**. Obtained data were compared and subsequently synthesized. Specifically, related concepts and ideas were identified and categorized into themes and subthemes. Consistency of these steps in data analysis and interpretation was maintained throughout the review of each article. Caution was exercised to prevent losing valuable insight and alternative interpretations. The final stage is **public presentation** for dissemination of review findings.

Findings

Profile of selected studies

Of the 42 publications retrieved, 29 met the inclusion criteria (18 primary studies, four reviews, five doctoral dissertations, two

master's theses). These studies were conducted in the UK (41%), USA (31%), Canada (14%), Australia (10%) and Iceland (3%). The countries of origin for participating INs covered nations across the globe. Research designs comprised qualitative (62%), mixed methods (21%) and quantitative descriptive (3%) approaches. Review articles comprised the remaining 14%. Facilitators and barriers to the transition of INs in their new workplace environments were identified, and chronicled in the following sections. These findings are also summarized in Table 1.

Facilitators to international nurses' workplace adjustment

Positive work ethic

It was not unusual for INs to work longer hours, assume heavier patient loads and tackle multiple challenges when they entered their new workplaces. '*We are hard working. We can't enjoy a break . . .*' (Withers & Snowball 2003, p. 286). By working hard, INs increased their confidence and enhanced their interpersonal skills. They learned the host country language more efficiently and came to understand the differences in nursing practice between their home country and the new country (Yi 1993). Furthermore, working hard prevented complaints from other staff and fostered positive peer support. '*Wherever you go, you do your best. Then, they can not find fault in you . . .*' (Yi 1993, p. 254). INs also had the deep-seated desire to prove themselves in order to survive, succeed and gain recognition. '*I have to prove myself that I can be one of them* [host country nurses] *. . .*' (Alexis & Vydelingum 2005b, p. 469). Indeed, many nurse managers endorsed the hardworking values of INs (Buchan 2003).

Persistence

INs demonstrated determination and perseverance by learning to strategize for survival, developing coping mechanisms, and becoming resilient both at work and in daily life: '*This is where I chose to become and to be and where the good outweighs the bad*' (Lopez 1990, p. 155). Some changed jobs to start anew instead of giving up when they became dejected, while others showed resolve through efforts to understand their peers: '*Have you considered that maybe they have never worked with Black people before? . . . they are not sure how to relate to us . . . we have to help them*' (Allan et al. 2004, p. 122).

Psychosocial and logistical support

Despite logistical support such as airport meet/greet and accommodation or transitional programmes offered by some employers, most were perceived inadequate and non-specific to INs (Matiti & Taylor 2005). Instead, the majority found support from fellow INs and social groups (Davison 1993). These social support systems and informal networks allowed stress reduction and minimized 'culture shock:' '*Whenever I was off, I went to my friends' houses . . . If I had no friends, I might not have survived* (Yi 1993, p. 247).

Learning to assume an assertive role

Because of different cultural upbringing, learning to be assertive in their new workplace took years for many INs (Yi 1993). To develop this attribute, INs learned to ask questions and defend their rights, thus earning respect (Lopez 1990) and making them better patient advocates (Withers & Snowball 2003): '*. . . there are some who bully me, so sometimes they poke me . . . I poke them twice . . . Before I am a small fish, now I'm a shark . . .*' (Allan & Larsen 2003, p. 66).

Continuous learning

Many INs looked at being in a different culture as a learning opportunity (Withers & Snowball 2003). Their self-directed learning included increasing knowledge on new technology and skills because '*it is more challenging here . . . you have more responsibilities*' (Lopez 1990, p. 91). Some upgraded their education, especially when they did not qualify as registered nurses upon arrival in the host country (Baumann et al. 2006).

These themes were the identified facilitators from the reviewed studies. Knowing these facilitators will lend to recognizing what needs to be considered in programmes designed to assist the adjustment of INs when they arrive in their new foreign workplaces.

Barriers to international nurses' workplace adjustment

Language and communication inadequacy

One pressing issue encountered by INs was communication challenge (Cooke 1998; Spangler 1991; Yi 1993). Differences in pronunciation, accent and terminologies limited INs' expression and understanding. Likewise, it was challenging to understand the sociocultural aspects of communication as in jokes, sarcasm, euphemisms and non-verbal behaviours (Baumann et al. 2006). Oftentimes, these nuances led to miscommunication and unfavourable perception by INs to provide effective, safe patient care: '*. . . there can be about five words I don't understand and that can be dangerous . . . I was also afraid that I would hurt someone just because I said something wrong*' (Magnusdottir 2005, p. 266). The absence of non-verbal cues made telephone communication most stressful because of fear of miscommunication and harm to patients. '*During the first few days on the job, I ran to the bathroom when the phone rang*' (Yi 1993, p. 93). In order to compensate for their language inadequacy and because they missed their culture (Withers & Snowball 2003), INs at times spoke in their native

Table 1 Facilitators and barriers for international nurses during adjustment

Studies	*Setting of studies*	*Facilitators*	*Barriers*
Alexis & Vydelingum (2004)	NHS in England		Experienced difficulty in grammar, accent, non-verbal cues, causing humiliation; felt marginalized because of cultural identity; not accommodated by hospital staff, with minimal support from British colleagues; ill-prepared about UK health-care system; felt degraded when attending to patients' basic needs; developed few skills with little hope for promotion; experienced racism because of differences, unable to speak up for fear of reprisal
Alexis & Vydelingum (2005a)	Primarily NHS in UK*		Treated unfairly and denied opportunities because of racism as cultural differences led to marginalization
Alexis & Vydelingum (2005b)	NHS in England	Proved self to gain recognition; gained support from Black people/minority ethnic colleagues	Unappreciated despite working long hours, no support from UK colleagues or benefit from performance reviews; lacked opportunities for skill development, denied training despite vast experiences; assigned 'worst' patients
Allan & Larsen (2003)	UK	Gained personal strength, positive coping strategies, self-confidence and support from colleagues, including an induction programme (meet and greet, mentor/buddy)	Experienced disrespect from staff and patients because of different accent/dialect; understanding of cultural differences limited (INs seen as rude when not looking straight in the eye); unsupported by colleagues, including lack of preparation, information and mentoring; overburdened by paperwork, policies and legal restrictions; lacking professional development; felt discriminated for being 'foreign;' exploited (undesirable shifts), bullied and perceived lack of trust from patients
Allan et al. (2004)	UK	Reached out to host country nurses; learned to cope with racism	Excluded socially with 'limited career progression,' with differences in language, color and culture used as determinants for racism
Baumann et al. (2006)	Canada	Going back to school to upgrade nursing qualifications	Experienced difficulty at understanding sociocultural aspects of communication (jokes, sarcasm, anger); challenged when registering and obtaining educational upgrade to meet requirements; dissatisfied with mentorship and orientation; felt unfamiliar with new nursing culture and differences in practice
Buchan (2003)	UK	Participated in induction programme with 3 to 6 months adaptation period with a mentor	Challenged by differences in language, clinical practice and technical skills; lacked assertiveness; undervalued despite previous experiences; endured workplace racism, negative patient reactions and complaints
Chung (1986)	US		Experienced deficiencies in English language and nursing experience; endured cultural differences
Cooke (1998)	England	Supported by host staff, who created positive opportunities and experiences	Misunderstood because of language issues; unacknowledged by staff despite INs' skills
Daniel et al. (2001)	London	Accepted and supported by staff; helped by induction programme	Experienced communication issues, costly living, differences in nursing practice and expectations: family does not help patients, elderly not held in high regard, heavy workload, higher nurse–patient ratio, too much specialization and concerns with verbal orders because of legal risks
Davison (1993)	USA	Determined and hard working (long hours); supported through sociocultural events, family	Limited by language obstacles, accents; unable to understand American way of life (elderly in rest homes, lack of 'close knit' family relationships); did not speak up and had quiet, passive or submissive personalities; experienced discrimination (less wages, undesirable shifts, perceived 'disrespect from patients')
DiCicco-Bloom (2004)	USA	Persisted, with work resilience	Displaced culturally: belonging to two places at one time yet not fully belonging to either; alienated by racism, oppression

Table 1 Continued

Studies	*Setting of studies*	*Facilitators*	*Barriers*
Hagey et al. (2001)	Canada	Strategized to cope and survive; supported by family, church, close friends	Unsupported for educational advancement; marginalized, experienced reprisal when complained about racism
Jackson (1996)	Australia	Sought comfort from other minorities, ultimately developed sense of belongingness – 'finding a place'	Experienced communication problems, differences in gender roles that caused difficulty with expectations and assertiveness at workplace; felt like a 'stranger,' with negative/unhelpful behaviour from colleagues, without extended families for support; lacked recognition and advancement; experienced horizontal violence and racism
Konno (2006)	Australia*	Formed informal networks with nurses sharing similar experiences	Experienced communication issues and cultural incongruence: conflict between expected work roles and culturally accepted roles; felt like a 'stranger,' with lack of support seen at workplace; not trusted, and endured rudeness and negative attitudes/behaviours; assisted minimally with nursing registration
Likupe (2006)	NHS in UK*		Not recognized for previous experiences; 'discriminated in pay and work conditions;' 'exploited by managers,' 'harassed racially'
Lopez (1990)	USA	Accepted, tolerated, endured, persevered and worked hard; had social support networks, diversionary activities and prayer; cohabitated; gained respect and improved interpersonal relationships by years of assertiveness; learned English and developed technical skills	Able to speak English but had difficulties with different accents, expressions, terminology; feared answering phone; lacked assertiveness, being submissive to gain approval, avoided direct confrontation; unable to care for patients because of their refusal; experienced limited technical skills, nursing knowledge and differences in nursing role perception
Magnusdottir (2005)	Iceland	Did not quit easily, tackled initial, multiple challenges; gained support from patients, colleagues, community; endured months and years to develop confidence and overcome challenges	Had language barrier, resulting in fear of endangering patients
Matiti & Taylor (2005)	UK	Was self-reliant, strong, independent and patient; supported through 'meet and greet'	Experienced difficulty with English speed/accent; isolated by inadequate knowledge of different culture; prepared vaguely and incompletely, inducted non-specifically; 'deskilled and devalued;' unable to apply advanced skills learned from home country; relearned basic skills; overburdened with paperwork
Miraflor (1976)	USA	Was independent, self-reliant; turned to each other for support, joined Filipino organizations, lived together	Experienced communication difficulties, including accent, pronunciation, slang; lacked assertiveness; felt lonely, ill-prepared culturally; oriented inadequately (only 2–4 weeks); lacked leadership skills
Omeri & Atkins (2002)	Australia		Experienced 'silencing,' difficulty in spoken/written English, 'otherness;' and cultural separateness; unappreciated by host country staff for cultural diversity; not knowing where to go and who to ask; lacked recognition of skills and previous experiences, causing decreased professional worth and limited advancement
Sarsfield (1973)	USA		Lacked assertiveness, too dependent; affected by 'insensitive, rude' host country nurses
Sochan & Singh (2007)	Canada	Returned to school to meet nursing requirements	Experienced language and cultural difficulties, and decreased income; lacked educational requirements; decreased professional respect and dignity

Spangler (1991)	USA	Had seriousness and dedication to work, patience and worked hard to prove selves; developed acculturation in time (years)	Spoke to fellow INs in own language, limiting assimilation; experienced differences in lifestyle and culture; lacked assertiveness; differed in nursing practice; performed more basic care
Turrittin et al. (2002)	Canada	Reached out to host country nurses, understood that they were different and tried not to get excluded; stood strong against racism	Felt as 'other;' experienced problems when working in managerial position, patient refusal of care; underwent denial of racism by colleagues and employers, and experienced reprisal when complained
Winkelmann-Gleed & Seeley (2005)	London	Had supportive mentor and supervisors	Endured difficulties with way of life, gender roles; lacked support from patients, colleagues; differed in nursing practice; lacked promotional opportunities
Withers & Snowball (2003)	UK	Learned to adjust, worked hard and had a positive attitude/work ethic; helped by orientation programme and staff support; recognized advantages of assertiveness; regarded differences as learning experiences; took responsibility in professional advancement and learning	Had difficulties with medical terminology, idioms and abbreviations; experienced difficulty with way of life: including limited finances, high taxes and different culture; differed in nursing practice/ expectations: heavy workloads, staff shortages and technology; unable to perform some procedures; lacked assertiveness, opening oneself to exploitation and discrimination
Xu (2007)	USA*		Challenged by communication (accent, telecommunication); displaced culturally; challenged interpersonally; differed in nurses' roles, scope of practice, and technical and legal environment; marginalized, discriminated and 'exploited'
Yi (1993)	USA	Desired to prove oneself and worked hard; increased interaction with staff/ patients helped in learning language and understanding differences in nursing practice; realized it was important to understand and accept differences to avoid maladaptation; gained support from other Korean nurses to reduce 'culture shock;' supported by other hospital staff and nursing administration; developed assertiveness in later phase of adjustment (several years); expressed feelings; made requests; asked why; said no; defended rights; learned English continuously by in-service education, watching TV programmes, listening to radio and reading English textbooks/journals	Experienced language barrier issues and 'culture shock,' causing confusion, misunderstanding, psychological stress and difficulty in interpersonal relationships; felt discomfort when calling people by last name or elders by first name; ill-prepared culturally upon arrival – improved with time spent (about 5 years for some)

NHS, National Health Service; INs, international nurses.
*Review studies.

languages at the workplace, unintentionally worsening discord with peers and perpetuating the perception of communication deficiency (Spangler 1991).

Differences in culture-based lifeways

Lifeways refer to values, beliefs and practices of an individual's or group's culture (Leininger 1995). Many INs lacked knowledge and understanding of the host culture lifeways (Chung 1986). In addition, some of their own lifeways, such as avoidance of conflicts and lack of assertiveness, hindered their adjustment to Western health-care environments. For example, conflicts between expected roles (such as assertiveness) in a new culture/workplace vs. accepted behaviours in each IN's home culture (such as passivity) complicated their adjustment (Konno 2006). Furthermore, some INs found it difficult to detach from their own cultures and continued to rely on their original lifeways such as maintaining 'close knit' family relationships (Davison 1993).

Additional challenges included dealing with interpersonal conflicts. Whereas most INs were noted to be quiet and anxious to please, host country nurses were perceived as insensitive and sometimes rude (Allan & Larsen 2003). There also appeared to be a lack of understanding of the INs' cultures which could have assisted in supporting INs' adjustment; however, cultural diversity was rarely acknowledged by host country nurses (Omeri & Atkins 2002). Consequently, INs often felt 'homesick,' stereotyped and marginalized. '*. . . I realized that even if we are a very egalitarian society, I am a second class citizen . . . I come from a different culture . . . I am still treated as stranger*' (Omeri & Atkins 2002, p. 502). There was a sense of cultural displacement – being attached to two places at one time, yet not fully belonging to either (Dicicco-Bloom 2004).

Lack of support

Many INs felt there was inadequate support from staff, colleagues and supervisors in their adjustment to new work environments. At arrival in their host country, there was a lack of logistical assistance such as airport 'meet and greet,' accommodation or transportation. Unsupportive attitudes and behaviours from peers were not uncommon (Sarsfield 1973). Many INs felt disappointed, misunderstood and mistreated, which fostered feelings of resentment, inferiority and even humiliation (Alexis & Vydelingum 2004, 2005b). '*Not knowing where to go and who to ask*' (Omeri & Atkins 2002, p. 500) was not uncommon.

Inadequate pre- and post-arrival orientations

Quite often, INs were not completely aware of all the required information regarding registration and licensure before departure from the home country. Some INs were disillusioned at having to work as nursing aides after realizing upon arrival that they did not meet the criteria as registered nurses (Baumann et al. 2006). Post-hire orientation programmes ranged from 2 to 4 weeks, with few beyond 6 weeks (Allan & Larsen 2003). Most INs felt their orientation was inadequate in content and length. '*I started work about four days after I arrived here and I [was] just literally given my patient . . . I think I went to orientation one day*' (Allan & Larsen 2003, p. 42). Generally, the programmes were non-specific to the unique needs of INs: '*It was a general induction for the whole staff who had applied to work in this hospital . . . It does not deal with cultural needs*' (Matiti & Taylor 2005, p. 12).

Differences in nursing practices

Many INs realized the incongruence between job expectations and actual demands. Examples included high acuity of patients, increased physical demand and fragmentation of care (Daniel et al. 2001). They were not allowed legally to perform certain procedures they routinely performed in their home countries. This, in turn, led to the perception of being deskilled and devalued (Buchan 2003; Omeri & Atkins 2002). Surprisingly for most INs, families were not involved in patient care in the host country (Yi 1993). Many noted that more time was spent on paperwork than patient care. In addition, legal concerns in Western litigious healthcare environments imposed further stress: '*. . . I have to cover my back all the time . . . documented it . . . what is going to happen to you if the client turn around and sues you?*' (Allan & Larsen 2003, p. 88).

Inequality of opportunity

Some INs were denied opportunities for professional development and promotion (Winkelmann-Gleed & Seeley 2005). They attributed injustices to their ethnic identities, racism and the health-care system's hierarchical nature (Alexis & Vydelingum 2005b). Few were promoted to managerial positions even after the adjustment period. Racism was experienced, including bullying by staff, peers and supervisors, denial of supplementary pay for additional responsibilities or being given undesirable work assignments, shifts and lower wages (Davison 1993). Moreover, rejection of care by some patients was perceived as racially motivated. 'Foreignness,' minority ethnic identity, skin color and language differences became grounds for discrimination by both colleagues and patients (Xu 2007). However, denial of racism by colleagues and employers was prevalent (Turrittin et al. 2002), and some INs experienced termination or reprisal when they complained (Hagey et al. 2001).

These themes were the identified barriers to adjustment from the reviewed studies. Knowledge of these barriers is necessary in

order to structure programmes that consider these issues to assist the adjustment of INs in their new foreign workplaces.

Discussion and conclusion

Findings from this review indicate that facilitators and barriers co-exist during the adjustment period for INs. These factors can be grouped into two broad categories: internal and external. Internal factors refer to those factors that can be controlled by INs themselves, such as continuing education (facilitator) and lack of communication skills (barrier). In contrast, external factors are those that are beyond the control of INs, such as logistical support (facilitator) and inadequacies of orientation programmes (barrier). In order to promote the adjustment of INs within the shortest possible time, both internal and external factors need to be addressed in tandem to achieve optimal outcomes in integrating INs into their new workplace environments.

It is apparent that knowledge of both the facilitators and barriers regarding the adjustment of INs can benefit INs themselves, their employers and most importantly, patients. In fact, both preventative and corrective measures against the identified barriers can be implemented to optimize their adjustment. Based on the review findings, the following implications and recommendations are considered.

Implications for practice

It appears that developing and implementing an evidence-informed, multifaceted, transition programme for INs can be a comprehensive strategy to address the adjustment barriers of communication difficulties, lifeway conflicts, inadequate support and orientation, and practice differences. A comprehensive approach is necessary because most existing orientation programmes for INs are based on personal or institutional experiences – anecdotal evidence in other words, and untailored to the unique needs of INs (Matiti & Taylor 2005; Zizzo & Xu 2009). Specifically, an evidence-informed transitional programme is needed to address what facilitates (i.e. psychosocial and logistics support), and hopefully, minimizes the barriers. First, language and communication competence training, including idioms, phonetics, accent reduction and sociocultural dimensions of communication, should be a high priority (Konno 2006) because communicative competency directly affects patient safety and quality of care. Such a training component may appear an extra burden to employers of INs. However, research (Xu 2007) indicated that lack of communication and language skills is the most challenging issue facing INs, especially accented speech and telephone communication even after they met the language requirements before hire. Second, implementing a mentoring system such as a 'buddy' programme will be of special value in terms of both emotional and clinical support, especially during the initial adjustment period when such support is most needed (Withers & Snowball 2003). Third, assertiveness training would be useful (Alexis & Vydelingum 2004; Jackson 1996), especially in context of patient safety and advocacy. Fourth, emotional support such as a 'meet and greet' upon arrival, and logistical support in locating lodging and financial institutions, must be an integral part of the transitional programme to assist INs in meeting their immediate needs upon arrival in a new country (Miraflor (1976)). Lastly, assistance with registration and licensing procedures are beneficial (Sochan & Singh 2007). Without developing and implementing a comprehensive, effective transitional programme for INs, both organizational and patient outcomes, as well as the employer's reputation might be negatively affected.

Implications for research

Given the findings of this review, developing and testing an evidence-informed transitional programme is urgently needed. Specifically, to what extent does communicative competency and assertiveness training affect workplace adjustment for INs? How do support and mentoring programmes assist INs' adjustment to their new health-care workplace environments? What effects does a transitional programme have on the retention of INs? It is believed that applying an evidence-informed approach to developing transitional programmes for INs can begin to provide answers to these questions.

Implications for policy

Inequality based on race, gender, culture, national origin and language (including accent) is contradictory to social justice – one of the fundamental values of the nursing profession. Employers must provide equal opportunities and ensure fair treatment for each of their employees in tandem with existing employment laws, policies and regulations in the host countries (Daniel et al. 2001; Hagey et al. 2001; Xu 2007). More importantly, employers could strengthen the enforcement of policies as well as regulatory agencies.

In conclusion, with the global nurse shortage and increasing magnitude of IN migration, it is critical to address the adjustment issues of INs in new workplace environments. These barriers not only affect job satisfaction of INs and therefore, their retention, but also patient safety and quality of care. Multifaceted strategies involving concerted efforts to support the successful adjustment of INs are most likely to enhance job satisfaction and improve retention. Identifying the facilitators and barriers provides the essential information needed to design an evidence-informed programme to meet the unique needs of INs as they adjust to new workplaces. Essentially, successful adjustment will

not only benefit INs themselves, but also their employers, and most importantly, the public cared for by INs.

Study limitations

First, it is likely that relevant studies may have been missed because of the constraints of limiting the literature search and selection to English language sources. Second, because there is infinite diversity in the experiences among INs of different ethnicities across vast geographical locations within contrasting health-care systems throughout the world, caution is warranted not to generalize findings of this review study beyond English-speaking Western countries represented.

Author contributions

JK was responsible for study conception, design and drafting of the manuscript with guidance and feedback from YX. YX provided majority of the studies. JK collected the data. JK and YX reviewed the data, performed the analysis and made critical revisions to the paper.

References

Aiken, L.H., et al. (2004) Trends in international nurse migration. *Health Affairs*, **23** (3), 69–77.

Alexis, O. & Vydelingum, V. (2004) The lived experiences of overseas black and minority ethnic nurses in the NHS in the south of England. *Diversity in Health and Social Care*, **1** (1), 13–20.

Alexis, O. & Vydelingum, V. (2005a) Overseas black and minority ethnic nurses: a systematic review. *Nurse Researcher*, **12** (4), 42–56.

Alexis, O. & Vydelingum, V. (2005b) The experiences of overseas black and minority ethnic nurses in the NHS in an English hospital: a phenomenological study. *Journal of Research in Nursing*, **10** (4), 459–472.

Allan, H. & Larsen, J.A. (2003) '*We Need Respect': Experiences of Internationally Recruited Nurses in the UK*. Royal College of Nursing, London.

Allan, H., Larsen, J.A., Bryan, K. & Smith, P.A. (2004) The social reproduction of institutional racism: internationally recruited nurses' experiences of the British health services. *Diversity in Health and Social Care*, **1**, 117–125.

Baumann, A., Blythe, J., Rheaume, A. & McIntosh, K. (2006) *Internationally Educated Nurses in Ontario: Maximizing The Brain Gain*. McMaster University, Hamilton, ON.

Buchan, J. (2003) *Here to Stay? International Nurses in UK*. Royal College of Nursing, London.

Buchan, J. & Calman, L. (2004) *The Global Shortage of Registered Nurses: An Overview of Issues and Actions*. International Council of Nurses, Geneva.

Chung, H.J. (1986) *A Study of Korean Nurse Immigrants' Adaptation Experience to the Nursing Profession in the Los Angeles Area (California)*. Unpublished Doctoral Dissertation. University of Michigan.

Cooke, M. (1998) Overseas nurses' experiences of working in clinical settings in England, and the experiences of their hosts: a phenomenological study. NT R*esearch*, **3** (5), 349–359.

Cooper, H. (1989) *Integrating Research: A Guide for Literature Reviews*, 2nd edn. Sage Publications, Newbury Park, CA.

Daniel, P., Chamberlain, A. & Gordon, F. (2001) Expectations and experiences of newly recruited Filipino nurses. *British Journal of Nursing*, **10** (4), 254, 256, 258–265.

Davison, M.A. (1993) *Filipina Nurses – Voices of Struggle and Determination*. Unpublished Master's Thesis. University of California, Los Angeles.

DiCicco-Bloom, B. (2004) The racial and gendered experiences of immigrant nurses from Kerala, India. *Journal of Transcultural Nursing*, **15** (1), 26–33.

Hagey, R., et al. (2001) Immigrant nurses' experience of racism. *Journal of Nursing Scholarship*, **33** (4), 389–394.

Jackson, D. (1996) The multicultural workplace: comfort, safety and migrant nurses. *Contemporary Nurse*, **5** (3), 120–126.

Kingma, M. (2006) *Nurses on the Move: Migration and the Global Health Care Economy*. Cornell University Press, Ithaca, NY.

Konno, R. (2006) Support for overseas qualified nurses in adjusting to Australian nursing practice: a systematic review. *International Journal of Evidence-Based Healthcare*, **4**, 83–100.

Leininger, M.M. (1995) Theory of culture care diversity and universality. In *Nursing Theories: The Base for Professional Nursing Practice*, 4th edn (George, J.B., ed.). Appleton and Lange, Norwalk, CT, pp. 373–389.

Likupe, G. (2006) Experiences of African nurses in the UK National Health Service: a literature review. *Journal of Clinical Nursing*, **15**, 1213–1220.

Lopez, N. (1990) *The Acculturation of Selected Filipino Nurses to Nursing Practice in the United States*. Unpublished Doctoral Dissertation. University of Pennsylvania.

Magnusdottir, H. (2005) Overcoming strangeness and communication barriers: a phenomenological study of becoming a foreign nurse. *International Nursing Review*, **52**, 263–269.

Matiti, M.R. & Taylor, D. (2005) The cultural lived experience of internationally recruited nurses: a phenomenological study. *Diversity in Health and Social Care*, **2** (1), 7–15.

Miraflor, C.G. (1976) *The Philippine Nurses: Implications for Orientation and In-service Education for Foreign Nurses in the United States*. Unpublished Doctoral Dissertation. Loyola University of Chicago.

Omeri, A. & Atkins, K. (2002) Lived experiences of immigrant nurses in New South Wales, Australia: searching for meaning. *International Journal of Nursing Studies*, **39**, 495–505.

Pilette, P.C. (1989) Recruitment and retention of international nurses aided by recognition of the phases of the adjustment process. *Journal of Continuing Education in Nursing*, **20** (6), 277–281.

Polsky, D., Ross, S.J., Brush, B.L. & Sochalski, J. (2007) Trends in characteristics and country of origin among foreign-trained nurses in the United States, 1990 and 2000. *American Journal of Public Health*, **97** (5), 895–898.

Sarsfield, N. (1973) *An Acculturative Study of the Filipino Nurse into New Jersey Hospitals*. Unpublished Doctoral Dissertation. New York University.

Sochan, A. & Singh, M.D. (2007) Acculturation and socialization: voices of internationally educated nurses in Ontario. *International Nursing Review*, **54** (2), 130–136.

Spangler, Z. (1991) *Nursing Care Values and Caregiving Practices of Anglo-American and Philippine-American Nurses Conceptualized within*

Leininger's Theory. Unpublished Doctoral Dissertation. Wayne State University.

Turrittin, J., et al. (2002) The experiences of professional nurses who have migrated to Canada: cosmopolitan citizenship or democratic racism? *International Journal of Nursing Studies*, **39** (6), 655–667.

Winkelmann-Gleed, A. & Seeley, J. (2005) Strangers in a British world? Integration of international nurses. *British Journal of Nursing*, **14** (18), 954–961.

Withers, J. & Snowball, J. (2003) Adapting to a new culture: a study of the expectations and experiences of Filipino nurses in the Oxford Radcliffe Hospitals NHS Trust. *NT Research*, **8** (4), 278–290.

Xu, Y. (2007) Strangers in strange lands: a metasynthesis of lived experiences of immigrant Asian nurses working in Western countries. *Advances in Nursing Science*, **30** (3), 245–264.

Yi, M. (1993) *Adjustment of Korean Nurses to US Hospital Settings*. Unpublished Doctoral Dissertation. State University of New York.

Zizzo, K. & Xu, Y. (2009) Transitional programs for internationally educated nurses: a systematic review. *The Journal of Continuing Education in Nursing*, **40** (2), 57–66.

ANEXO IV – ESTUDIO DE CASOS

CASE 1

In the organization of work shifts and rounds, the nursing director carries out the schedule without consensus of his/her team. He/she makes de timetable taking into consideration his/her more veteran colleagues as he/she has friendly relationships with.

In view of this situation that always favor the closest workers to the nursing director, the youngest ones or those with lees experience are forced to comply unfavorable shifts that do not take into consideration their preferences, needs or availability.

- Would you consider this situation as a bullying case or one that could derive in?
- Why do you think the nursing director organizes the tasks in this way?
- How do you think the younger workers feel with this situation?
- How do you think the veteran ones feel?
- How would you act putting into practice compassionate leadership skills?
- Is this a case that takes place in real practice?

CASE 2

A patient was derived to the treatment room by the GP. The person in charge of the cure was a nursing assistant.

After the cure, the patient went again to his/her GP room who did not like the treatment done by the assistant nurse and, so, he/she asked that a nurse explained the procedure to the assistant. This nurse was very upset about this, so he/she decided to do him/herself the cure to the patient at the same time he/she addressed to the assistant with a clear pejorative tone treating him/her as inexpert and inefficient.

In view of this situation, the assistant left the treatment room to avoid a conflict that disfavor the patient.

- Would you consider this situation as a bullying case or one that could derive in?
- Why do you think the nurse reacts in this way?
- How do you think the nursing assistant feels?
- Do you consider this situation can affect the quality of the care provided to the patient?
- How would you act putting into practice compassionate leadership skills?
- Is this a case that takes place in real practice?

CASO 3

A medical surgeon from Cuba considers appropriate to remove stitches from a knee injury so the healing continues without any bandages. On the other hand, the nurse in charge of removing the stitches considers more convenient that the wound continues covered and not to remove the stitches yet. So, he decides to ask the presence of the surgeon to discuss and analyze together the situation.

After the analysis, the surgeon takes the last decision and decides to proceed as she initially considered appropriate. In view of that, the nurse protests and shouts xenophobic insults to the surgeon in the presence of other colleagues disowning her figure saying that she comes from an undeveloped country and undermining her training and education.

- Would you consider this situation as a bullying case or one that could derive in?
- Why do you think the nurse reacts in this way?
- How do you think the surgeon feels?
- How do you think the other colleagues feel?
- Do you consider this situation can affect the quality of the care provided to the patient?
- Do you consider the cultural factor hinders a respectful treat towards the surgeon?
- Do you consider this situation can affect the working environment?
- How would you act putting into practice compassionate and culturally competent leadership skills?
- Is this a case that takes place in real practice?

CASE 4

In a primary care centre there is a very integrated nursing team with a large trajectory working together so they know each other very well. Recently a much loved nurse has retired and a new one from Romania has arrived to take up her place. This new nurse does not feel very comfortable in her new work as she cannot get integrated with the rest of the team. Their peers invite to have coffee or lunch between themselves in front of her but usually they exclude her. She has tried twice to set up talks or to invite for a coffee but without success. It seem that the team does not accept the change of the old colleague.

- Would you consider this situation as a bullying case or one that could derive in?
- Why do you think the rest of the team reacts in this way?
- How do you think the new nurse feels?
- How do you think the other nurses feel?
- Do you consider the cultural factor hinders her integration within the team?
- Do you consider the cultural factor is a barrier to be empathetic and respectful towards the new nurse?
- Do you think that developing very closed human teams may hinder the inclusion of new members?
- Do you consider this situation can affect the quality of the care provided patients?
- Do you consider this situation can affect the working environment?
- How would you act putting into practice compassionate and culturally competent leadership skills?
- Is this a case that takes place in real practice?

CASE 5

The head nurse perceives that one her workers in general is uncooperative, with little patience and willingness. The head is tired of this attitude and transmits her antipathy discomfort without any discretion between the rest of the team, which favors that her opinion becomes generalized.

When there are optional training courses, chances to attend conferences or collaboration in research projects, both the head nurse and the rest of nurses exclude her automatically.

- Would you consider this situation as a bullying case or one that could derive in?
- Do you think the opinion of the head impact on those of the rest of the team?
- Why do you think the head nurse reacts in this way?
- How do you think the criticized nurse feels?
- How do you think the rest of the team feels?
- Do you consider this situation can affect the working environment?
- How would you act putting into practice compassionate leadership skills?
- Is this a case that takes place in real practice?

ANNEX V – ACTION PLAN FOR ROLE MODELLING

Your name:

Your profession and role:

Date:

SCENARIO 1

Have you detected a bullying case or not appropriated behaviours/attitudes in your work context? If so, please, describe the situation: since when?; what kind of negative behaviours or attitudes do you observe?; how does this situation affect to the victim?; how does this situation impact on the bully?; etc.

Have you detected any case of bullying or discriminatory behaviours/attitudes against workers from other countries, with different cultures or religions? If so, please, describe the situation.

Who are the people you would like to include in your role modelling to change or improve this/these situation/s?

How do you plan to put into action your cultural competence, compassion, tolerance and understanding within your team? Please, describe specific actions and attitudes.

ANNEX V – ACTION PLAN FOR ROLE MODELLING

SCENARIO 2

Equity, respect or empathy are values very important at the workplace. In this regard, leaders are vital for transmission of these and other values daily in the way they communicate with their teams, deal with problems and organize the work. You are asked to think about these points:

When you distributes tasks, responsibilities (for instance, distribution of on-call duty hours):

- Is the distribution equal?

- Do you take into consideration personal issues for decision making?

- Are you influenced by sympathies?

- Do you discriminate in some way international nurses?

After that, if you have detected bias in your attitudes and behaviours, you are encouraged to improve gradually these issues in order to transmit positive values among your teams. Describe an alternative solution and way for the distribution of tasks being more equal, compassionate and culturally competent.

ANNEX V – ACTION PLAN FOR ROLE MODELLING

SCENARIO 3

One of the organizational features and situations that can favour bullying attitudes and behaviours is when changes take place through introducing new procedures or issues. For this reason, it is very important you are aware how you approach these situations and deal with them. So, in relation with these situations, you are asked to reflect about these points:

- Do you appropriately explain and clarify new roles and activities of every person involved in the team?

- Are you more patient and compassionate with some persons than with others?

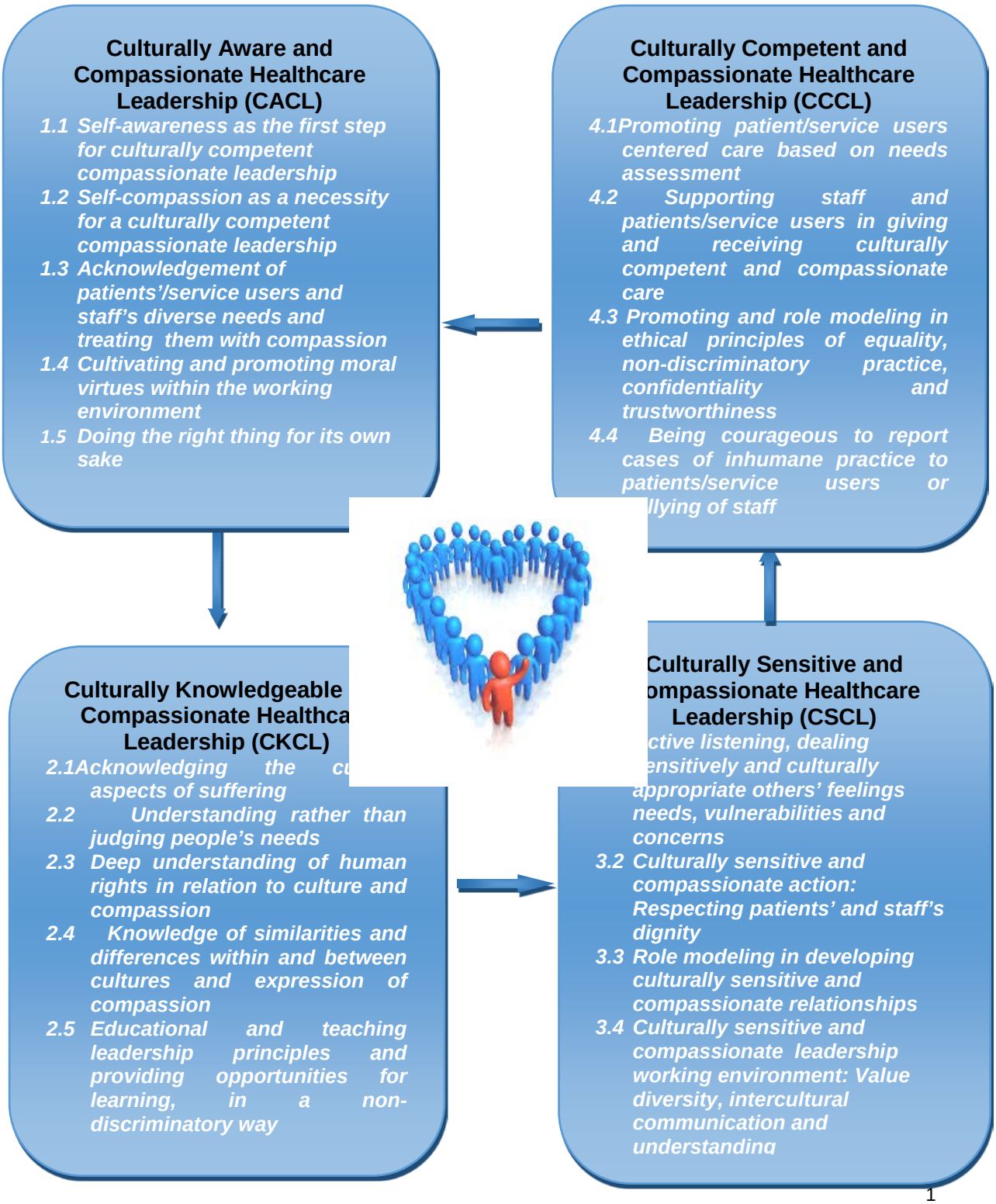
- In case you have professionals from other cultures working with you, do you allocate 'the worst' functions and tasks to them?

After that, if you have detected bias in your attitudes and behaviours, you are encouraged to improve gradually these issues in order to transmit positive values among your teams. Describe an alternative solution and way for the distribution of tasks being more equal, compassionate and culturally competent.

ANNEX VI – REFLECTION

Please, write a summary of your experience after carrying out the different activities of the module about the **awareness**, **sensitivity**, **knowledge** and **competence** gained in relation to **culturally competent and compassionate leadership**. You can inspire yourself through the **European Model for developing Culturally Competent and Compassionate healthcare Leadership** you can find below.

Later, please, send this document to the course trainer by email: ascension.donate@uv.es



ANNEX VI – REFLECTION

AWARENESS

Do you feel more aware about the subjects covered under the course? Yes ☐ No ☐

Please, explain briefly.

SENSITIVITY

Do you feel more sensible about the subjects covered under the course? Yes ☐ No ☐

Please, explain briefly:

KNOWLEDGE

Do you feel with more information and knowledge about the subjects covered under the course? Yes ☐ No ☐

Please, explain briefly.

COMPETENCE

Do you feel more competent about the subjects covered under the course? Yes ☐ No ☐

Please, explain briefly: